Deloitte.

Commonwealth of Kentucky

Medicaid Expansion Report

2014

February 2015

Table of Contents

List of Figures

List of Tables

Executive Summary

When the Commonwealth of Kentucky decided to expand Medicaid eligibility as permitted by the Affordable Care Act (ACA)[1], it had the goals of: a) reducing the number of low-income residents in Kentucky who lacked health care, b) improving the health status of Kentuckians – especially low-income residents without prior access to health care coverage, and c) boosting Kentucky's economy.

This report examines progress toward these goals in the first 12 months of Medicaid expansion (January 1, 2014 to December 31, 2014) and updates initial estimates from the 2013 Medicaid Expansion Whitepaper based on this first year of experience. Findings from the analysis indicate that Medicaid expansion is having an overall positive impact in Kentucky for the period reviewed.

1. **A total of 310,887 Kentuckians enrolled in the Medicaid expansion by the end of State Fiscal Year (SFY)[2] 2014, which materially exceeded expectations.** Kentucky initially projected 147,634 newly eligible residents would likely enroll in Medicaid expansion in SFY 2014, along with another 17,059 residents who were previously eligible but not enrolled in Medicaid.

2. **National data indicates that Kentucky experienced the second largest decrease of any U.S. state in its uninsured rate through the first half of calendar year (CY) 2014, dropping from 20.4% to 11.9%.** Based on a Gallup report, the 10 states experiencing the largest reductions in state uninsured rates from CY 2013 to mid-year 2014 made the decision to expand Medicaid and establish state-based health insurance exchanges or state-federal partnerships (Witters, 2014). This observation suggests that ACA reforms beginning in January 2014 influenced uninsured rates in states across the nation, with Kentucky being a primary example.

3. **Medicaid expansion is estimated to have a significant positive cumulative impact of $30.1 billion on Kentucky's economy through SFY 2021.[3]** This is approximately twice the $15.6 billion estimated in the 2013 Medicaid Expansion Whitepaper. The economic impact is a result of direct spending on health care and its multiplier causing indirect and induced spending to occur.

4. **The net difference between expanding Medicaid and not expanding Medicaid is estimated to be a positive $919.1 million from SFY 2014 to SFY 2021.** This number is comprised of two parts: the $819.6 million positive fiscal impact of Medicaid expansion and the avoidance of a $99.5 million negative impact Kentucky may have experienced if it had not expanded Medicaid. Since there are cost implications to expanding or not expanding, the overall impact of Medicaid expansion must be considered collectively.

---

[1] As referenced in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

[2] The Kentucky State Fiscal Year (SFY) is July 1st to June 30th.

[3] After SFY 2021, the model reaches relative stability.

- **Based on CY 2014 enrollment and future estimated enrollment, the Commonwealth's Medicaid expansion is estimated to have a positive fiscal impact of $819.6 million between SFY 2014 and SFY 2021, slightly more than the $802.4 million estimated in the 2013 analysis.** While enrollment and expenditures are greater than initial estimates, the Commonwealth has made additional policy decisions and has greater knowledge of Medicaid expansion since the initial analysis, causing additional savings to be identified that were not known during the 2013 analysis.

- **Experience from other regional non-expansion states suggests that Kentucky could have incurred costs of $99.5 million between SFY 2014 and SFY 2021 if it had not expanded Medicaid.** This estimated cost is primarily attributable to the enrollment of individuals who were previously eligible but not enrolled in Medicaid. These individuals may have signed up for Medicaid even without Medicaid expansion, as occurred in most surrounding non-expansion states.

5. **Based on Kentucky Medicaid claims data, the state's health care system and overall economy realized an infusion of $1.16 billion.** This additional revenue is driven by new federal payments to health care providers for Medicaid expansion members in CY 2014.

6. **Hospitals experienced a reduction of $1.15 billion in uncompensated care charges when comparing the first three quarters of CY 2013 to the same period in CY 2014.** This may be an effect of increased access to health insurance from Medicaid expansion and kynect, which generally reduces uncompensated charges.

7. **The Urban Studies Institute at the University of Louisville (USI) estimates that through SFY 2021, Medicaid expansion will create more than 40,000 jobs – almost 23,000 jobs more than estimated in the 2013 Whitepaper – with an average salary of about $41,000.** Based on estimates, Medicaid expansion created more than 12,000 jobs in SFY 2014, including 5,400 health care and social services jobs.

8. **Medicaid expansion provides an opportunity for additional economic and societal gains through improved health outcomes.** Previously uninsured individuals will have access to primary care and preventive services, which may lead to better health. This opportunity for improved health may contribute to additional positive fiscal impacts for the Commonwealth.

9. **Medicaid expansion has provided the newly enrolled with access to health care services.** This population is accessing preventive services at a rate equal to, and in some instances greater than, the traditional Medicaid population that served as the comparison group for this study. This access to preventive care may be an important tool in addressing the Commonwealth's chronic disease burden. For example, 90,000 Medicaid expansion members received cholesterol screening and 80,000 members received preventive dental services.

10. **Medicaid expansion offers opportunity for improvements in substance use disorder treatment, a long-existing health care issue for Kentucky.** Based on analysis of provider enrollment and claims data, more than 300 new behavioral health providers have enrolled in Kentucky Medicaid and at least 13,000 individuals with a substance use disorder have received related treatment services since January of 2014.

The following report includes a more detailed analysis of these and other related topics, offering an update on Kentucky's Medicaid expansion experience in its first year.

I. A Year of Medicaid Expansion

Background on the decision to expand Medicaid. The Affordable Care Act (ACA), signed into law on March 23, 2010, introduced significant provisions to expand access to health care coverage nationwide, including expanding Medicaid to 138% of the Federal Poverty Level (FPL). On June 28, 2012, the United States Supreme Court's ruling effectively provided each state with the choice of whether to expand its Medicaid program, setting up a state-by-state decision (National Federation of Independent Business (NFIB) v. Sebelius, 2012).

The Medicaid program in Kentucky has historically focused on providing health care to certain subgroups among the Commonwealth's lowest-income individuals – the elderly, disabled, children, pregnant women, and/or parents. ACA provided an opportunity to expand the population served and to specifically extend coverage to adults with incomes up to 138% of the FPL. Figure 1 on the following page illustrates the Medicaid eligibility income levels for eligibility groups in Kentucky without ACA. Figure 2 illustrates the eligibility income levels for these same groups with ACA (including Medicaid expansion and Qualified Health Plans sold on Kentucky's Health Benefit Exchange, kynect). Income eligibility levels are shown separately for individuals eligible for traditional Medicaid and for children qualifying for coverage under the Kentucky Children's Health Insurance Program (KCHIP). Details on the 2014 FPL guidelines can be found in Table 31 of the Appendix.

Figure 1. Medicaid Eligibility Income Levels without ACA

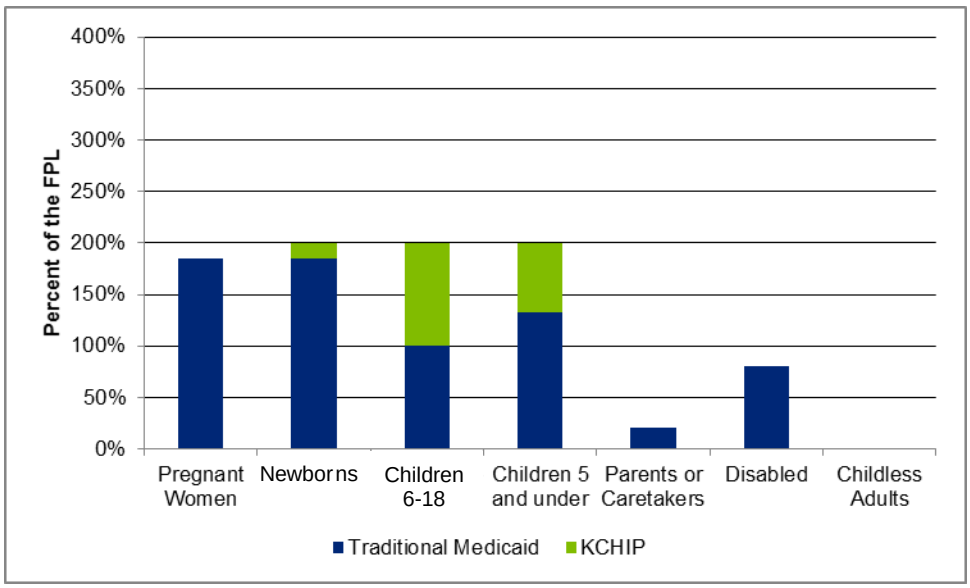
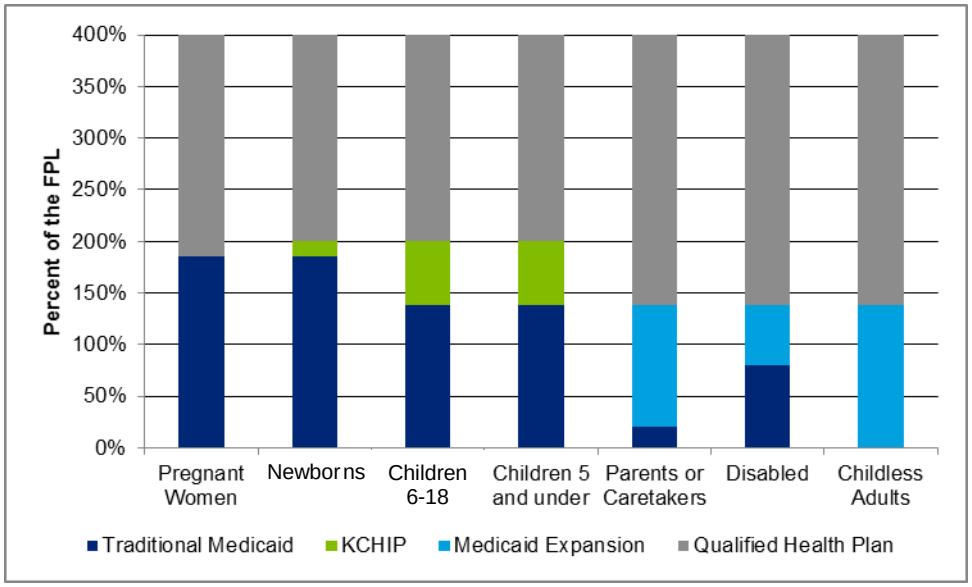


Figure 2. Medicaid Eligibility Income Levels with ACA



In 2013, Governor Steven L. Beshear asked the Commonwealth's Cabinet for Health and Family Services (CHFS), with assistance from Pricewaterhouse Coopers, and the Urban Studies Institute at the University of Louisville (USI), to conduct an analysis in order to make a more informed decision on Medicaid expansion in Kentucky. The study, titled *Analysis of the Affordable Care Act Medicaid Expansion in Kentucky,* analyzed the potential impact of Medicaid expansion on the state's expected Medicaid expansion population[4], the state budget, and the economy (hereafter referenced as the "2013 Whitepaper").

The 2013 Whitepaper concluded that Medicaid expansion would be beneficial to the state, and in May 2013 Governor Beshear announced his decision to expand Medicaid to include individuals with incomes up to 138% of the FPL. CHFS, in collaboration with the Centers for Medicare & Medicaid Services (CMS), made the required policy changes to begin enrolling Medicaid expansion members on October 1, 2013, with coverage beginning on January 1, 2014.

As newly eligible Kentuckians continue signing up for coverage under Medicaid expansion, the state is experiencing a period of significant change that has the potential to alter Kentucky's economy and health care landscape. Furthermore, previous studies suggest insurance coverage through Medicaid expansion offers the opportunity to positively impact Kentucky's historically poor health rankings.

With the close of the first year of Medicaid expansion, the Commonwealth asked Deloitte Consulting LLP (Deloitte)[5] to develop this report with the assistance of CHFS, Kentucky's Medicaid actuary – Aon Consulting, and USI in order to better understand Medicaid expansion's initial impact on Kentuckians, the Commonwealth, and the overall Kentucky health care system. Using claims data, as well as other internal and external data sources, this report analyzes impacts over the first calendar year (CY) of Medicaid expansion (January 1, 2014 to December 31, 2014)[6] and assesses the impact of Medicaid expansion on the Kentucky economy, Commonwealth expenditures, savings, and enrollment. This report uses the CY 2014 experience to revise estimates of future enrollment, expenditures, and economic impact. The results serve as a resource for state leaders, policymakers, health care providers, and the general public to understand how Medicaid expansion has affected the Commonwealth in its first year of implementation, as well as potential implications for future years.

[4] The Medicaid expansion population includes legal residents with incomes below 138% of the FPL.

[5] As used in this document, "Deloitte" means Deloitte Consulting LLP. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

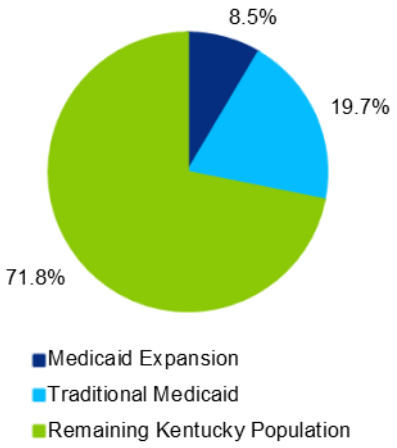
[6] There is a customary lag between the date health care services are received and the date a claim is submitted for payment. Because of this lag, there are likely claims with dates of service in 2014 that were not included in the data used for this analysis.

Medicaid Expansion Enrollment

First-year enrollment of Medicaid expansion exceeded initial projections. The 2013 Whitepaper estimated enrollment levels based on the federal Congressional Budget Office (CBO) research. With 2014 data now available, it is possible to compare first-year experience to those estimates. The 2013 Whitepaper estimated that 147,634 newly eligible members would enroll in the Medicaid expansion group during State Fiscal Year (SFY) 2014 (July 1, 2013 to June 30, 2014), with enrollment increasing to 187,898 by SFY 2021.

For the first six months of CY 2014 (coinciding with the end of SFY 2014), state data indicates that enrollment for Kentucky's Medicaid expansion population reached 310,887 enrollees and grew to 375,175 enrollees by the end of CY 2014, thus exceeding original expectations. Both the total annual enrollment and pace of enrollment materially exceeded the 2013 Whitepaper projections, suggesting that assumptions about the number of individuals that would enroll (the "take-up" rate) were low and that there was pent-up demand for health care coverage among Kentucky's Medicaid expansion population. At the close of CY 2014, Kentucky's Medicaid expansion population represented approximately 8.5% of the state's total population. Overall Medicaid enrollment (traditional and expansion) now represents 28.2% of the overall Kentucky population.

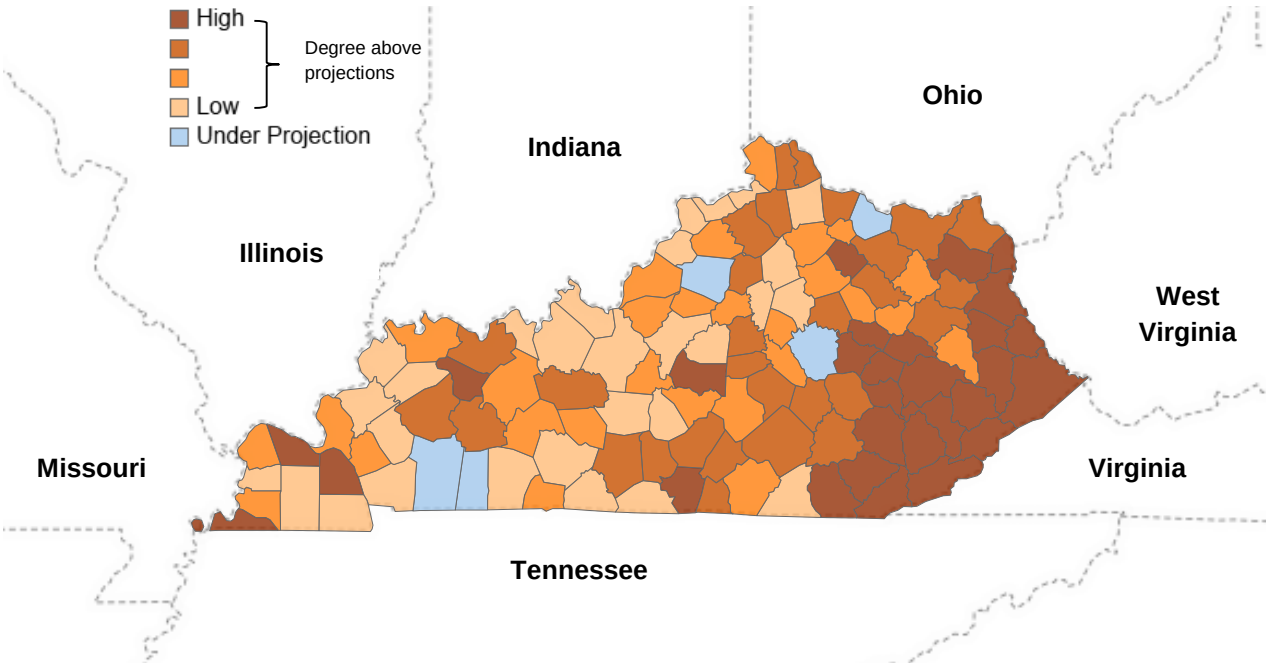
Figure 3. State Population Distribution as of December 31, 2014



Besides exceeding 2013 Whitepaper projections, first-year Medicaid expansion enrollment exceeded census-based estimates of potential eligible enrollees, as was the case in many other Medicaid expansion states. The 2010 U.S. Census' Small Area Health Insurance Estimate (SAHIE) estimated that Kentucky had approximately 308,000 uninsured individuals under age 65 whose income was below 138% of the FPL, representing the expansion-eligible population (United States Census Bureau, 2012).

Figure 4 examines each of the 120 counties in Kentucky and compares the CY 2014 Kentucky Medicaid expansion enrollment to census estimates of Medicaid expansion-eligible enrollees. Five counties colored in blue experienced enrollment below the census values. The other 115 counties are divided into quartiles based on the degree that enrollment exceeded census estimates of expansion-eligible enrollees.

Figure 4. Medicaid Expansion Enrollment vs. Census-Estimated Potential Enrollment



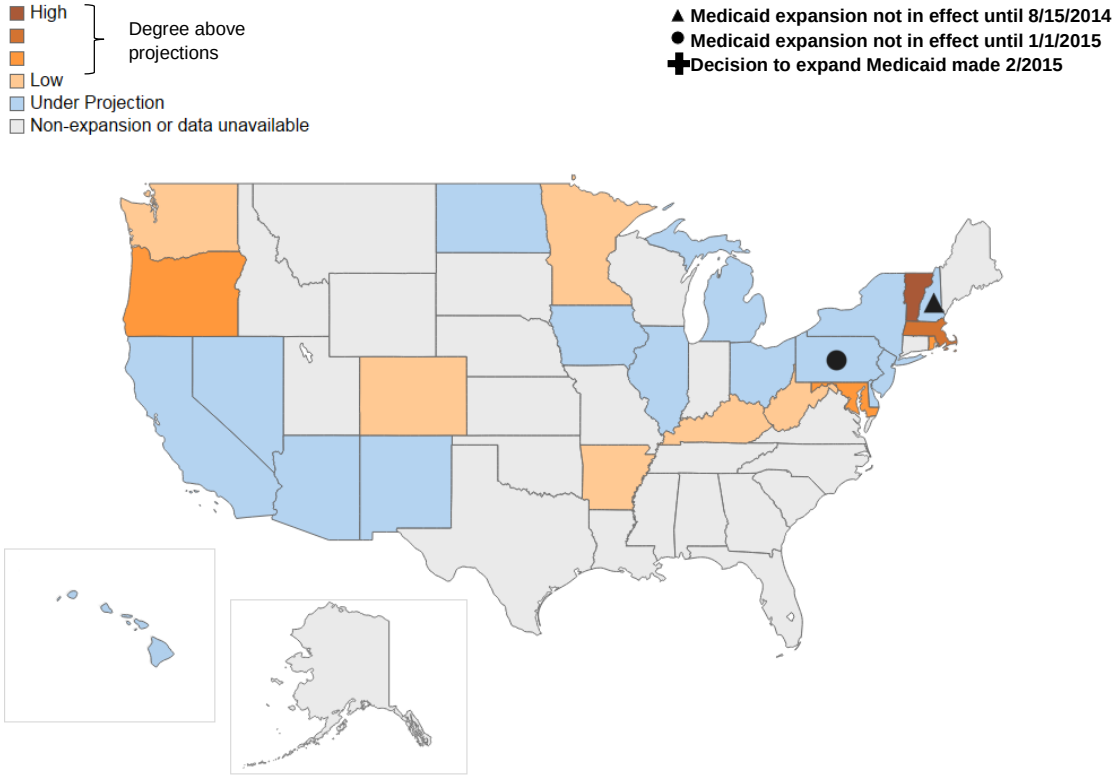
The largest concentration of counties that exceeded the census-estimated potential enrollees is located in eastern Kentucky, which borders one expansion state, West Virginia, and two non-expansion states, Virginia and Tennessee. Meanwhile, counties that border other non-expansion states, including Tennessee and Indiana, are in lower quartiles. While there had been some hypotheses that Medicaid expansion would lead uninsured individuals to migrate from non-expansion states to bordering Medicaid expansion states to obtain Medicaid coverage, Kentucky's experience seems to contradict those hypotheses that individuals are migrating across states to obtain Medicaid coverage, which is consistent with recently published peer-reviewed research (Schwartz & Sommers, 2014).

Kentucky was not alone in surpassing Medicaid expansion enrollment expectations. Data from CMS and the U.S. Census suggests 11 of the 28 other states[7] that expanded Medicaid also surpassed census estimates of potential Medicaid expansion-eligibles in the first year (Figure 5 on the following page). Tables including this information and details on each state's Medicaid expansion status are included in Tables 24 and 25 of the Appendix. The high enrollment in Kentucky and nationally relative to census estimates suggests potential issues with the 2010 U.S. Census methodology for estimating the uninsured population in 2010. The U.S. Census has since announced that it is materially changing that methodology in order to provide more precise measures of uninsured rates (United States Census Bureau, 2014).[8]

[7] New Hampshire expanded Medicaid in August 2014. Pennsylvania's Medicaid expansion did not begin until January 2015. Indiana authorized expansion in 2015. Data was not available for Connecticut.

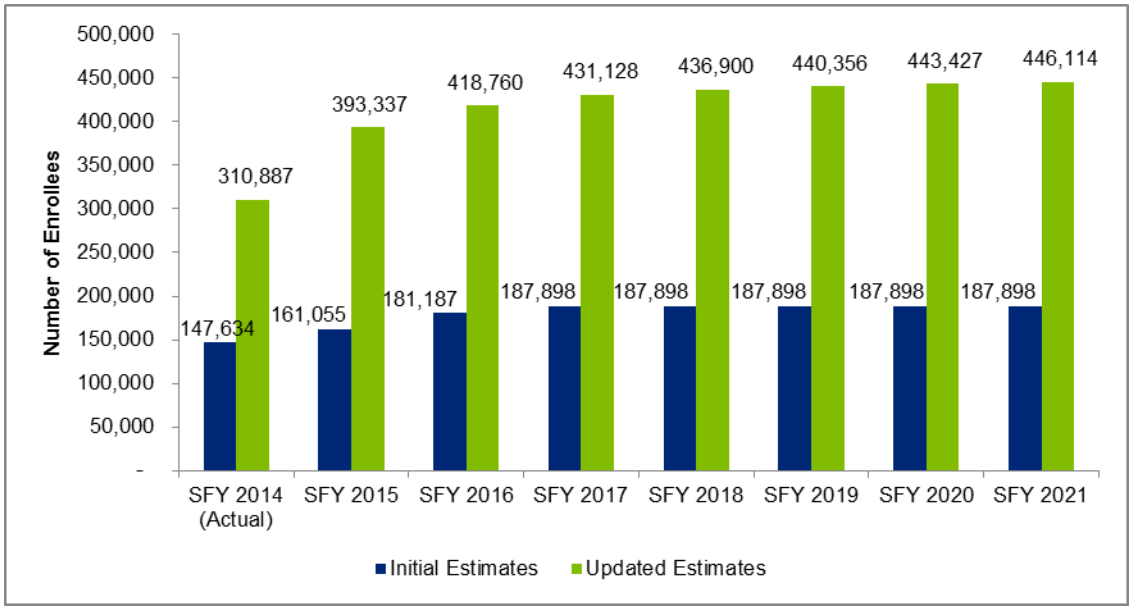
[8]The proposed changes in methodology are significant enough that comparisons to historical information may not be possible.

Figure 5. First-Year Enrollment vs. Census-Estimated Potential Enrollment in Medicaid Expansion States (percentage difference)



With Kentucky's first-year enrollment exceeding the original SFY 2021 estimate, future enrollment estimates have been revised accordingly. Updates to estimated enrollment by SFY are based on a combination of full CY 2014 Medicaid enrollment experienced by Kentucky and projections of nationwide Medicaid enrollment from the 2013 *Actuarial Report on the Financial Outlook of Medicaid* produced by CMS (Office of the Actuary, CMS, HHS, 2013). To update the 2013 Whitepaper's estimates of future Medicaid expansion enrollees, this report applies the national Medicaid enrollment trends produced using CMS total Medicaid enrollment projections through federal fiscal year (FFY) 2021 to Kentucky's base enrollment realized in SFY 2014. Because Kentucky participated in Medicaid expansion for all of CY 2014, trends were calculated on the CMS enrollment scenario that assumed full Medicaid expansion. Figure 6 on the following page compares revised estimated enrollment of newly eligible enrollees based on CMS growth estimates to initial estimates from the 2013 Whitepaper. After SFY 2021, the model reaches relative stability.

Figure 6. Updated Estimates of Newly Eligible Enrollment vs. Initial Enrollment Estimates, SFY 2014-2021



The CMS future enrollment rate estimates were published in 2013 before the higher-than-anticipated, first-year Medicaid expansion enrollment information was available. Because of the higher first-year enrollment, it is likely that future-year enrollment estimates are overstated since they are based on growth rates that assumed a much lower first-year take-up rate. Moreover, the CMS report estimated enrollment data at a national level; it is not specific to Kentucky.

It is important to note that future-year estimates are inherently subject to volatility. Medicaid enrollment is heavily influenced by economic variables on a state-by-state basis. If the future economic outlook is optimistic and state unemployment is anticipated to be low, then Medicaid enrollment is likely to be lower than anticipated. Alternatively, if the economic outlook is pessimistic, Medicaid enrollment is likely to be higher than anticipated.

Enrollment of Prior-Eligibles (Woodwork)

With the announcement of Medicaid expansion, states anticipated that some individuals previously eligible for traditional Medicaid but not enrolled would learn of the opportunity for coverage through outreach and media attention about ACA. This concept has been colloquially referred to as the "Woodwork" effect. Some individuals in the prior-eligible population became new Medicaid enrollees in 2014 even though they were eligible for Medicaid prior to 2014. Enrollment of prior-eligibles was expected in both Medicaid expansion and non-expansion states. While Medicaid expansion directly increased Medicaid enrollment in expansion states, 18 of 22 non-expansion states also experienced increased Medicaid enrollment from individuals and families who were previously eligible for coverage (Office of the Actuary, CMS, HHS, 2013).

Similar to the experience for Medicaid expansion, enrollment of prior-eligibles exceeded projections. The 2013 Whitepaper anticipated an increase in traditional Medicaid enrollment of 17,059 members in SFY 2014, increasing to 21,711 in SFY 2017, and remaining at that level through SFY 2021. Like the Medicaid expansion estimates, the 2013 Whitepaper's projected enrollment estimates for prior-eligibles were based on CBO research.

Based on 2014 data, the prior-eligible population was estimated at 36,702 enrollees at the end of SFY 2014. Like Medicaid expansion enrollment, first-year enrollment of prior-eligible recipients has surpassed the initial enrollment expectations for the end of SFY 2021.

It is important to note that enrollment of prior-eligibles contributed to Medicaid enrollment growth across the U.S. regardless of an individual state's decision to expand Medicaid. Based on CMS enrollment data, Table 1 shows the estimated 2014 Medicaid enrollment growth for non-expansion states in the southeast and Kentucky border states, along with Kentucky's estimated enrollment increase from prior-eligibles (Office of the Actuary, CMS, HHS, 2013). The percentage increase in enrollment for non-expansion states (assumed to be that for prior-eligibles) is similar to that of Kentucky, a Medicaid expansion state. Based on surrounding state information, it can be inferred that Kentucky could have experienced a similar enrollment of prior-eligibles whether or not the Commonwealth decided to expand Medicaid.

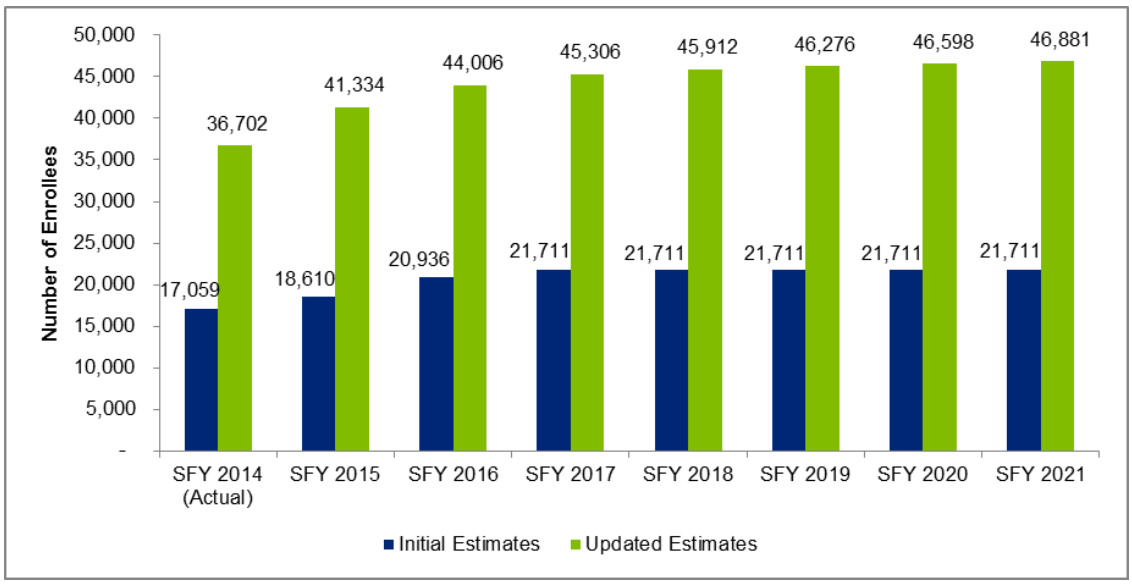
Table 1. Change in Enrollment in Regional Non-Expansion States, September 2013-September 2014

State	Net Change Enrollment	Percent Change
Alabama	61,433	7.7%
Florida	245,733	7.9%
Georgia	202,599	13.2%
Indiana*	68,959	6.2%
Kentucky	36,702	6.0%
Louisiana	28,067	2.8%
Mississippi	52,692	8.3%
Missouri	-29,540	-3.5%
North Carolina	92,204	5.3%
South Carolina	82,977	10.5%
Tennessee	115,921	9.3%
Virginia	-52,537	-5.2%

*Indiana authorized Medicaid expansion in 2015; the data available regarding enrollment represents the period while it was a non-expansion state.

Revised growth estimates for the prior-eligible population were calculated using the same methodology as estimates for Medicaid expansion growth, using CMS' future enrollment growth estimates and Kentucky data. Figure 7 on the following page displays the revised estimate of prior-eligible enrollment compared to the 2013 Whitepaper estimates. In Kentucky, prior-eligible enrollment at the end of SFY 2014 was greater than the original estimate of 17,059 members. By the end of SFY 2021, it is estimated that enrollment of prior-eligible members will exceed initial projections by 25,170.

Figure 7. Updated Estimates of Prior-Eligible Enrollment vs. Initial Enrollment Estimates, SFY 2014-2021



Based on 2014 enrollment data, approximately 60% of the SFY 2014 prior-eligible enrollees are children. This distinction is notable since a portion of children receive a 100% federal funds match compared to the remaining prior-eligible population, which is matched at the traditional federal level of about 70%.

Like the Medicaid expansion estimates, the prior-eligible estimates are based on CMS' estimated enrollment growth rates. As noted previously, the enrollment growth estimates may be overstated since the higher-than-expected Medicaid expansion take-up rate for the first year was not known at the time CMS issued its estimated enrollment growth rates.

Impact of Medicaid Expansion on Uninsured Rates in Kentucky

The uninsured rate in Kentucky has decreased significantly since the start of ACA. Medicaid expansion – combined with commercial plans purchased on the state's health benefit exchange, kynect (Qualified Health Plans or QHPs) – and increases in traditional Medicaid individuals (the prior-eligibles) have helped to significantly reduce Kentucky's uninsured rate. According to Gallup, Kentucky experienced the second largest drop in uninsured (from 20.4% in 2013 to 11.9% in mid-year 2014 for a 42% or an 8.5 percentage point decline) of any state in the nation (Witters, 2014).

Figure 8. Kentucky kynect Enrollment by Type of Coverage, CY 2014

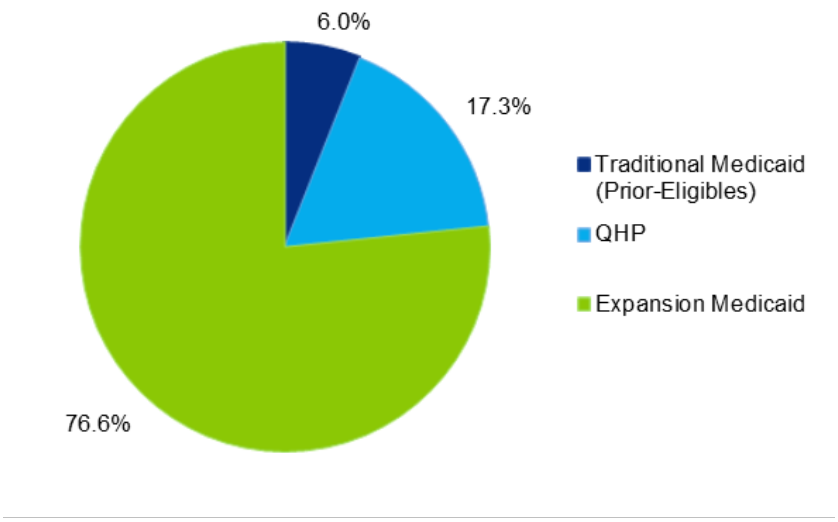
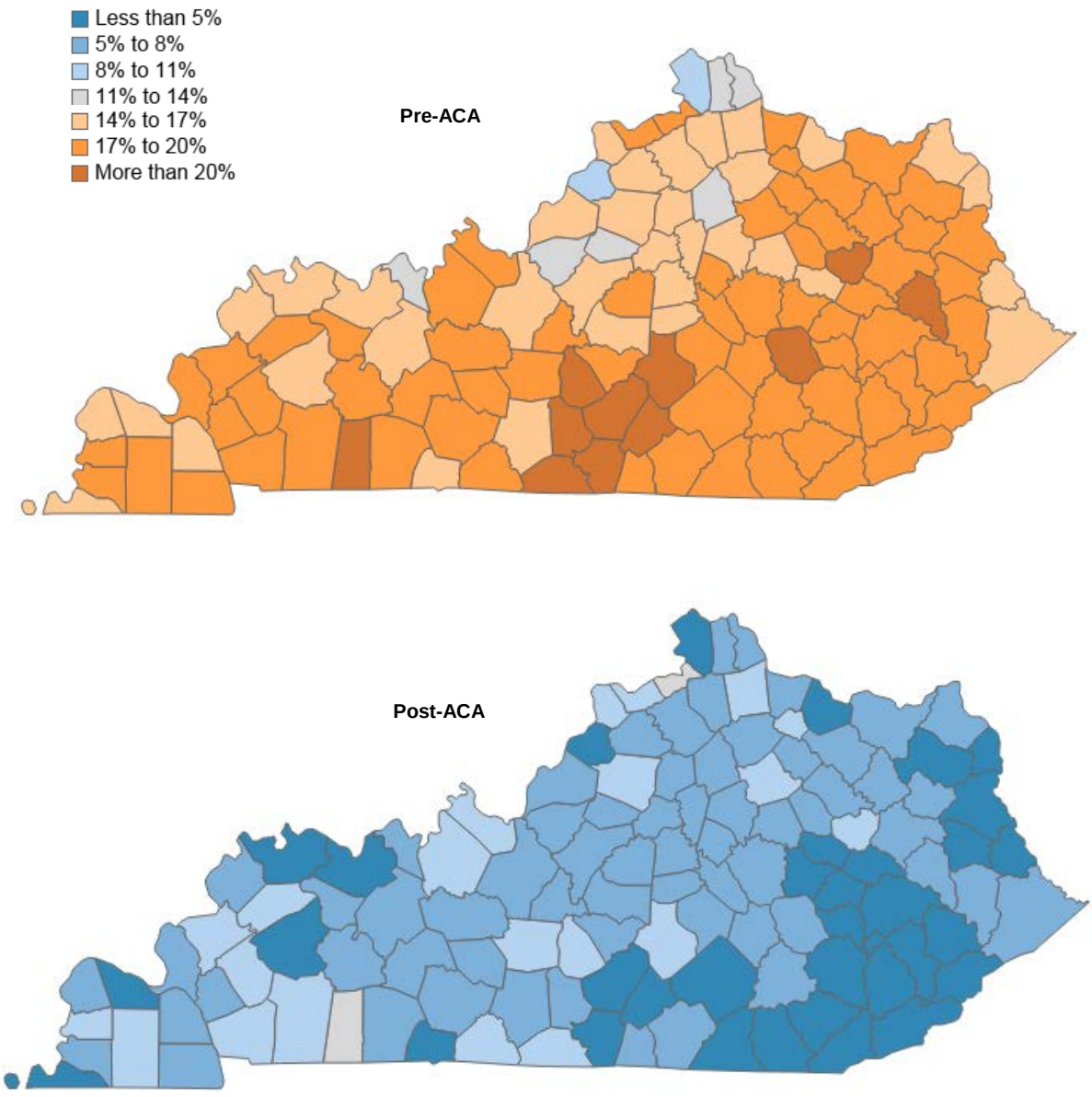


Figure 9 on the following page compares the uninsured rate by county in Kentucky before ACA and the uninsured rate estimated after ACA based on estimates from the U.S. Census Bureau (United States Census Bureau, 2012).

Kentucky's aggressive outreach and marketing efforts were likely a driver for the state exceeding targeted enrollment for Medicaid expansion. Outreach occurred at numerous county fairs and festivals throughout the summer and fall of 2013. Kentucky also engaged advocates and community organizations as kynectors and assisters. This outreach also involved area development districts, community mental health centers (CMHC), local health departments, community action agencies, faith-based organizations, hospitals, clinics, and other health care providers. More than 95% of Kentucky's population was reached through these efforts (Kentucky Health Benefit Exchange).

Figure 9. Uninsured Population Per Capita



II. Updated Economic Impact

The collective economic impact of Medicaid expansion to the Commonwealth of Kentucky remains positive with an estimated fiscal impact of $819.6 million from SFY 2014 to SFY 2021. As noted previously, Medicaid expansion participation was much higher than originally anticipated. First-year Medicaid expansion enrollment and estimated enrollment for subsequent years will impact Kentucky's Medicaid program budget once the federal share of cost coverage, known as the Federal Medical Assistance Percentage (FMAP), begins to decline in CY 2017 (see Table 2). However, the state's share of the investment in Medicaid expansion cannot be viewed in isolation since there are positive economic impacts from the infusion of federal dollars into the state economy as well. The first year of Medicaid expansion shows signs of these positive impacts:

- Based on Kentucky claims data, Medicaid expansion added $1.16 billion in new Medicaid revenues to health care providers in Kentucky in CY 2014. Hospitals alone received $506.6 million in statewide hospital revenues while significantly reducing uncompensated care charges, creating financial gains for the provider community.
- Implementation and ongoing adoption of Medicaid expansion appear to be an economic stimulus to the Commonwealth. USI and the Bureau of Labor Statistics (BLS) estimate that more than 12,000 total jobs, including 5,400 health care sector jobs, were created from Medicaid expansion spending during SFY 2014, the first year of the program.
- Analysis by Kentucky's Medicaid actuary, Aon Consulting, has estimated SFY 2016 Managed Care Organization (MCO) rates for the Medicaid expansion population to be lower than the SFY 2015 rates paid to MCOs for this population.[9]

Table 2. Enhanced FMAP Percentages for Medicaid Expansion, CY 2014 and Beyond

CY	Enhanced FMAP Percentage
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and beyond	90%

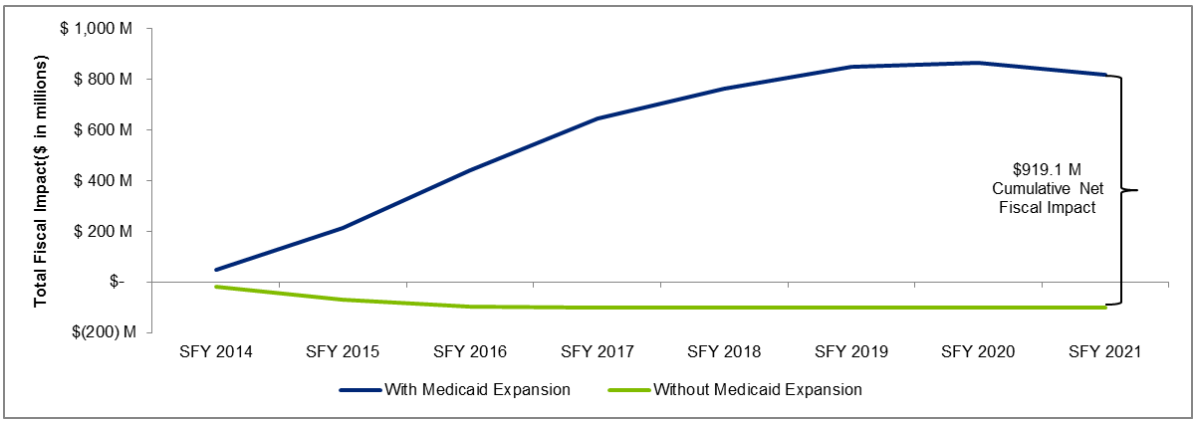
[9] Kentucky's first year of experience parallels national experience reported in a CMS Office of the Actuary analysis. In that report, CMS projects that expenditures for the Medicaid expansion population will decrease from FFY 2014 to 2015 and again in FFY 2016 (CMS, Office of the Actuary, 2013).

The 2013 Whitepaper estimated that Medicaid expansion would result in a net $802.4 million positive fiscal impact for Kentucky from SFY 2014 to SFY 2021, which is slightly lower than updated estimates. Applying enrollment and expenditure growth rates from CMS to enrollment and expenditures in SFY 2014 for newly eligible and prior-eligible Medicaid individuals, as well as the impact of policy changes, leads to revised estimates of the net economic impacts of ACA both with and without Medicaid expansion. The revised net economic impact of expanding Medicaid for Kentucky from SFY 2014 to SFY 2021 is estimated to be $819.6 million based on Kentucky enrollment and cost information, CMS estimated enrollment and expenditure growth rates, and economic modeling by USI. Using the same methodology and sources, the impact of not expanding Medicaid is estimated to be a net loss of $99.5 million. Details of these estimates, along with the 2013 analysis, are included in the Fiscal Impact Tables in the Appendix of this report (Tables 21, 22, and 23).

Using the cost projection assumptions referenced for the fiscal impact table, the state realized revenue gains and savings of $69.5 million in SFY 2014 compared to an increase in expenditures and/or loss of funds of $19.9 million in the same period, resulting in a net positive impact of $49.6 million in SFY2014. This net positive impact is estimated to continue through SFY 2020. Beginning in SFY 2021, expenditures in state funds are estimated to exceed state savings and revenue increases. This trend is due in part to increasing enrollment and member cost estimates and a lower federal matching percentage. However, by the end of SFY 2021, there is still an estimated net cumulative positive impact to the state of $819.6 million.

By choosing to expand Medicaid, Kentucky avoids the estimated $99.5 million cost of not expanding and thus is estimated to have a cumulative net positive impact from SFY 2014 to SFY 2021 that is $919.1 million greater than if Kentucky chose not to expand Medicaid. It is important to recognize that there is a net cost to the state associated with a non-expansion decision – in essence, the investment in Medicaid expansion cannot be viewed independently of the related economic consequences to the state. Without Medicaid expansion, the state may not experience some of the near-term direct costs associated with the Medicaid expansion population, but the result of such a decision could be the forfeiture of the economic benefits associated with increased jobs and tax revenue. Moreover, the state could still experience many of the same reductions in federal dollars due to some of the provisions of ACA which could have occurred regardless of the decision to expand Medicaid and which are occurring nationwide. Kentucky likely would have also experienced the costs of the prior-eligibles, as states that did not expand Medicaid have encountered. In choosing to expand Medicaid, it is estimated the state avoids the negative cost of not expanding Medicaid, which should be considered as additive to the benefits of Medicaid expansion. This comparison is illustrated in Figure 10, which follows.

Figure 10. Estimated Cumulative Net Fiscal Impact with and without Medicaid Expansion



Federal Funds Replacement and General Fund Expenditure Reductions

Medicaid expansion provided the opportunity to replace General Fund dollars with a combination of federal and General Fund dollars, allowing for expenditure reductions. Governor Beshear proposed, and the General Assembly enacted, budget reductions to the following departments: Department for Public Health (DPH), Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID), and Department of Corrections (DOC). These reductions were proposed because Medicaid expansion made some persons served by these departments eligible for Medicaid or expanded the benefits available to existing persons served.

By making persons under 138% of the FPL eligible for Medicaid benefits and by expanding the substance use disorder and mental health benefits:

- Prisoners who are removed from correctional facility property for more than 24 hours for medical reasons are now eligible to be covered by Medicaid;
- Adults under 138% of the FPL are now able to receive mental health treatment at CMHCs and other new provider types through Medicaid, which is funded by traditional or Medicaid expansion match, rather than exclusively through General Fund dollars;
- Adults under 138% of the FPL can now be treated for substance use disorders at CMHCs and other new provider types through Medicaid, which is funded by traditional or Medicaid expansion match, rather than exclusively through General Fund dollars; and
- Adults under 138% of the FPL can now receive medical treatment at Local Health Departments (LHD) through Medicaid, which is funded by traditional or Medicaid expansion match, rather than exclusively through General Fund dollars.

Because of the increased opportunities for these governmental and quasi-governmental agencies to replace funding that was exclusively through General Fund dollars with a combination of state and federal funds, General Fund amounts were reduced in the current biennium budget, and are estimated to continue, as shown in Table 3.

Table 3. Budgeted and Estimated General Fund Expenditure Reductions by Department

SFY	DBHDID	DPH	DOC	Total
2014	$9,000,000	$4,000,000	$5,400,000	**$18,400,000**
2015	$21,000,000	$6,000,000	$11,000,000	**$38,000,000**
2016	$30,000,000	$11,700,000	$11,200,000	**$52,900,000**
2017	$30,586,000	$11,925,000	$11,500,000	**$54,011,000**
2018	$31,216,000	$12,195,000	$11,700,000	**$55,111,000**
2019	$31,847,000	$12,420,000	$11,900,000	**$56,167,000**
2020	$32,477,000	$12,690,000	$12,200,000	**$57,367,000**
2021	$33,108,000	$12,915,000	$12,400,000	**$58,423,000**

The reductions to DOC for SFY 2014 were enacted in 2012 in anticipation of Medicaid expansion. These reductions were further increased in the most recently approved budget. The original reduction of $4,000,000 per year was increased to $5,400,000 in SFY 2014. In SFY 2015 and SFY 2016, this reduction will total $11,000,000 and $11,200,000 respectively, representing significant cost savings to the General Fund.

Another impact of Medicaid expansion is the reduction of state and local expenditures to the current Quality Care Charity Trust Funds (QCCT) paid to the University of Louisville Hospital to cover economically disadvantaged populations. Contributors to the QCCT fund are the Commonwealth of Kentucky, the Louisville Metro Government, and the University of Louisville (House Bill 235). Table 4 shows recent history and the planned contributions for each of these categories because of Medicaid expansion.

Table 4. Historical and Budgeted QCCT Contributions

SFY	Commonwealth of Kentucky	Louisville Metro	University of Louisville	Total
2010	$20,221,411	$9,643,104	$5,000,000	**$34,864,515**
2011	$19,918,100	$9,643,104	$5,000,000	**$34,561,204**
2012	$19,718,900	$9,643,104	$5,000,000	**$34,362,004**
2013	$17,588,427	$7,000,000	$5,000,000	**$29,588,427**
2014	$17,788,168	$7,000,000	$5,000,000	**$29,788,168**
2015*	$6,000,000	$5,000,000	$5,000,000	**$16,000,000**
2016*	$4,000,000	$3,000,000	$5,000,000	**$12,000,000**

*Budgeted levels

The overall payments decrease by more than $17 million from SFY 2013 to SFY 2016. These reductions are offset by the Medicaid expansion coverage of more low-income citizens, reducing the need for subsidized care funded by QCCT payments.

The impact of reduced Disproportionate Share Hospital (DSH) payments on hospitals will be offset due to an increase in patient revenue and a delay in DSH reductions by the federal government until CY 2017. As indicated in the 2013 Whitepaper, ACA was designed to substantially reduce the number of uninsured individuals in the U.S. Accordingly, ACA also reduced federal DSH payments to states. The reductions were scheduled to occur regardless of whether a state chose to adopt Medicaid expansion. DSH payments were designed to help states provide support to hospitals that serve a significantly disproportionate number of low-income, uninsured patients.

The estimated fiscal impact of reductions in DSH payments is displayed in Table 5. Since DMS pays the state share associated with non-teaching hospital DSH payments, the Commonwealth will save between $3.9 million in state funds in SFY 2017 and up to $10.4 million in SFY 2021. Psychiatric hospital DSH funding is used to support Kentucky's state-owned facilities. State psychiatric hospitals are held harmless in this model.

Table 5. Estimated Impact of DSH Reductions

SFY	DSH Reductions	General Fund Savings
2014	$0	$0
2015	$0	$0
2016	$0	$0
2017	$24,400,000	$3,911,000
2018	$63,500,000	$10,177,000
2019	$63,500,000	$10,177,000
2020	$63,500,000	$10,177,000
2021	$64,900,000	$10,402,000

The current acute care distribution formula for DSH funds individual hospitals based on the proportion of care for individuals with incomes below 100% of the FPL. As a result of ACA and the implementation of Medicaid expansion, Kentuckians with incomes up to 138% of the FPL are now eligible for coverage through Medicaid. Therefore, a new method for determining DSH allocations will need to be developed for SFY 2017 and beyond.

When the new distribution methodology is developed, it will affect both the distribution and amount of funds received. The federal guidelines for determining DSH reductions under ACA are designed to:

- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high volumes of Medicaid inpatients; and
- Impose larger percentage reductions on states that do not target their DSH payments on hospitals with high levels of uncompensated care.

New eligibility rules defined under Medicaid expansion have created opportunities for traditionally eligible Medicaid members to now qualify under Medicaid expansion, creating savings to the General Fund. Prior to Medicaid expansion, Kentucky covered specific groups of individuals through special eligibility categories who may now qualify under Medicaid expansion, thus creating a savings to the General Fund. Table 6 illustrates the traditional eligibility requirements for these special types of Medicaid recipients.

Table 6. Programmatic Eligibility

Eligibility Group	Eligibility Description	Eligibility Requirements	Medicaid Expansion
Breast and Cervical Cancer Screening Treatment Program (BCCTP)	Women aged 21 to 65	• No insurance • Breast or cervical cancer diagnosis • Income below 250% FPL	Income at or below 138% FPL
Spend-Down	• Children • Parents • Caretakers • Aged, blind, or disabled	• Child in the home or disability determination • Incurred medical expenses exceed monthly income • Assets below $2,000	
Transitional Medical Assistance (TMA)	Former Kentucky Transitional Assistance Program (K-TAP)	• Weekly work requirements • Assets below $2,000	
Nursing Facility (Adult Medicaid)	Disabled adults	• Administrative disability • Possible estate recovery of farm or home • Assets below $2,000	

Historically, Kentucky was liable for approximately 30% of the costs to cover each of these types of recipients, while the remaining 70% was funded by the federal government. With ACA's requirement to use only adjusted income to determine eligibility for most Medicaid enrollees, individuals in these special eligibility categories may qualify for Medicaid through the expansion based exclusively on their income level and not be required to provide documentation of their special eligibility status as previously required. If these traditionally eligible members become income-eligible through Medicaid expansion, the state's share of the cost of care for these individuals from CY 2014 to CY 2017 drops from approximately 30% to 0%. After CY 2017, the Commonwealth will be liable for sharing an increased percentage of the cost, up to a maximum of 10% beginning in CY 2020. Even with the 10% contribution, this opportunity still creates a per capita budget savings compared to the 30% state share for traditional eligibility. Table 7, which follows, provides estimated reductions to the cost of providing Medicaid for these recipients as a result of Medicaid expansion.

Table 7. Estimated General Fund Cost Reductions for Special Enrollment Categories

SFY	BCCTP	Spend-Down	K-TAP	Nursing Facility	Total
2014	$392,000	$2,397,000	$1,900,000	$1,700,000	**$6,389,000**
2015	$1,336,000	$13,983,000	$9,000,000	$7,900,000	**$32,219,000**
2016	$1,732,000	$37,200,000	$9,700,000	$9,700,000	**$58,332,000**
2017	$1,930,000	$37,200,000	$9,500,000	$9,500,000	**$58,130,000**
2018	$1,970,000	$37,200,000	$9,200,000	$9,700,000	**$58,070,000**
2019	$2,002,000	$37,200,000	$9,100,000	$10,100,000	**$58,402,000**
2020	$2,027,000	$37,200,000	$8,900,000	$10,300,000	**$58,427,000**
2021	$2,047,000	$37,200,000	$8,800,000	$10,600,000	**$58,647,000**

ACA requires states to provide Medicaid coverage to former foster care children through age 25, replacing a General Fund program. In SFY 2013 Kentucky incurred medical costs for former foster children since it extended commitment for health care coverage beyond age 18 due to educational, employment, or disability considerations. As a result of the changes in ACA, the Commonwealth has discontinued its policy of purchasing health insurance policies for foster children using General Fund dollars since the foster children can receive Medicaid coverage with associated federal funding. This change results in cost savings as outlined in Table 8. The updated estimates are based on SFY 2014 experience, budgeted amounts, and estimated growth.

Table 8. Estimated General Fund Savings for Foster Care

SFY	Medical Expenditure Savings
2014	$1,000,000
2015	$1,100,000
2016	$1,100,000
2017	$1,129,000
2018	$1,149,000
2019	$1,169,000
2020	$1,198,000
2021	$1,218,000

ACA contains a provision that increases each state's enhanced Children's Health Insurance Program (CHIP) FMAP by 23 percentage points. Given Kentucky's already high CHIP FMAP, this will result in KCHIP claims and capitation being covered with 100% federal funds beginning in SFY 2016. Estimated General Fund savings from enhanced KCHIP FMAP is detailed in Table 9 on the following page.

Table 9. Estimated General Fund Savings from Enhanced KCHIP FMAP

SFY	KCHIP Savings
2014	$0
2015	$0
2016	$24,600,000
2017	$35,000,000
2018	$37,400,000
2019	$40,000,000
2020	$42,900,000
2021	$45,800,000

Increased General Fund Requirements

ACA establishes 10 essential health benefits, which must be provided to newly eligible Medicaid members in states that expand Medicaid. In Kentucky, the primary change required to comply with the 10 essential health benefits was the addition of substance use disorder benefits. Costs for these benefits can be categorized into three distinct population groups: newly eligible members, prior-eligible members, and traditional Medicaid members. There is no cost associated with providing these benefits to newly eligible members through CY 2016, as the federal government reimburses expenditures at the 100% match rate. Beginning in CY 2017, the state will bear a portion of the cost of providing these new benefits. For prior-eligibles, the cost to the state is the traditional FMAP percentage for these new benefits. The remaining cost of new ACA-mandated benefits comes from providing the benefits to those already enrolled in Medicaid. These individuals, who did not have access to the benefits prior to January 2014, could begin receiving services at the start of Medicaid expansion. The cost impact of ACA-mandated benefit changes through SFY 2021 is estimated in Table 10 below.

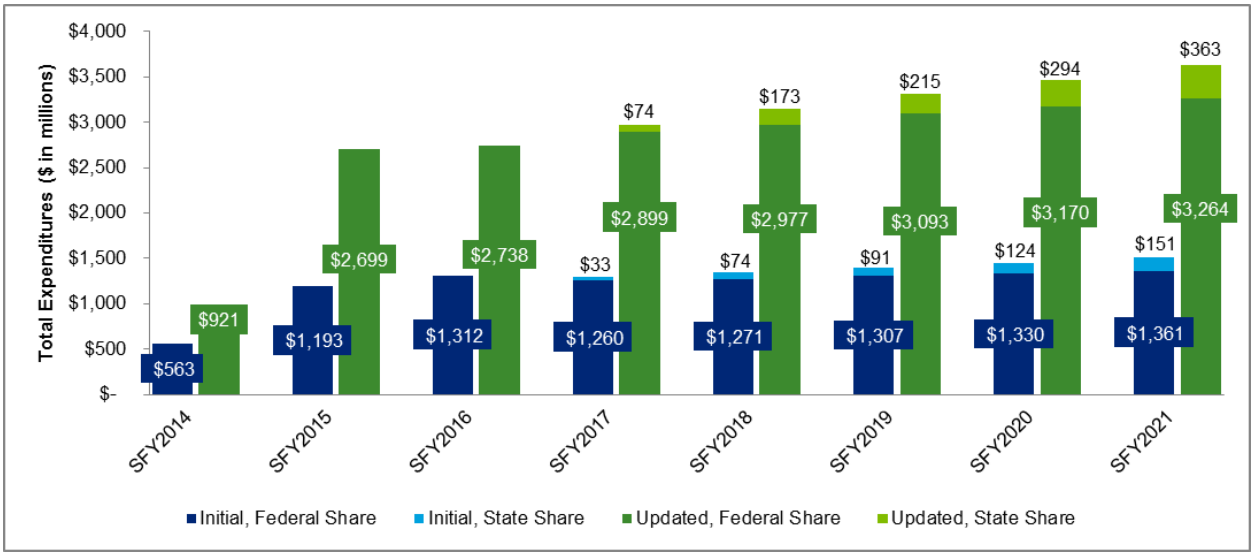
Table 10. Estimated Cost Impact of ACA-Mandated Benefit Changes

SFY	Cost
2014	$4,221,000
2015	$9,596,000
2016	$9,500,000
2017	$9,880,000
2018	$10,275,000
2019	$10,686,000
2020	$11,114,000
2021	$11,558,000

The largest cost drivers associated with Medicaid expansion include the expenditures associated with covering new Medicaid enrollees. Kentucky will not incur costs for Medicaid expansion members until CY 2017, when the federal match begins to decrease. However, expenditures for prior-eligibles – those who could have qualified for Medicaid without Medicaid expansion – began at the beginning of CY 2014. Given that these are non-expansion members, they are not eligible for the 100% FMAP offered for newly eligible enrollees and are reimbursed at the traditional FMAP. The FMAP for a given state is updated each FFY based on statewide adjusted gross income. For Kentucky, the traditional FMAP was approximately 70% as of FFY 2013. Table 26 in the Appendix includes a breakdown of Kentucky's FMAP percentage by year.

Figure 11 illustrates the revised estimated federal and Kentucky state share of expenditures required to cover the Medicaid expansion population. Estimated gross annual expenditures by SFY are based on a combination of CY 2014 Medicaid enrollment experience provided by Kentucky, along with enrollment and spending growth estimates from the most recent *Actuarial Report on the Financial Outlook of Medicaid* produced by CMS (Office of the Actuary, CMS, HHS, 2013). As noted in the 2013 Whitepaper, Kentucky bore no cost, and will continue to bear no cost, for newly eligible Medicaid members through SFY 2016.

Figure 11. Updated Estimate of Expenditures for Newly Eligible Population, SFY 2014-2021

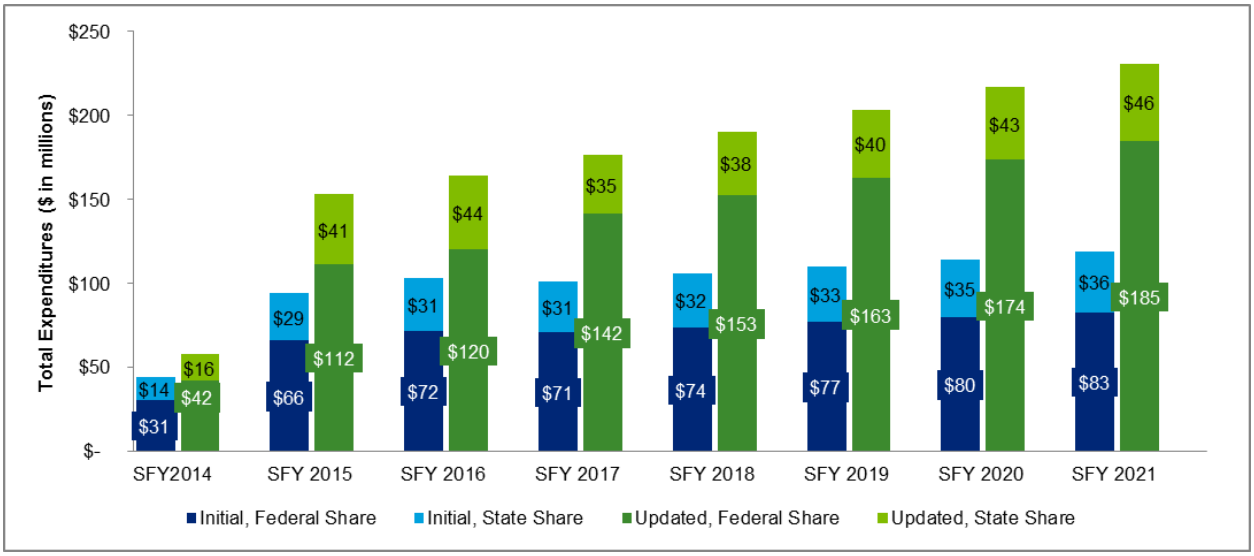


Beginning in SFY 2017, the state's annual share of the cost of newly eligible enrollees is estimated to be $74 million; it will increase over time to $363 million in SFY 2021. The model reaches relative stability after SFY 2021. The cause for the increase is twofold: 1) Medicaid enrollment increases during this time based on CMS estimates, and 2) the decline in federal matching dollars from a 100% match rate in CY 2014 through CY 2016 to a 90% match rate beginning in CY 2020.

The SFY 2021 cost of serving prior-eligible members is estimated to be $231 million, with the state share being $46 million. As previously discussed, prior-eligible enrollment in SFY 2014 outpaced earlier projections by 19,643. These additional members, along with the new projections, lead to additional costs for Kentucky. Figure 12 illustrates the revised estimated federal and Kentucky state share of expenditures required to cover the prior-eligible population, compared to the original estimates. Like the newly eligible expenditures estimate, this estimate is based on spending growth assumptions produced using CMS'

2013 *Actuarial Report on the Financial Outlook of Medicaid*. Claim costs for the prior-eligible population were based on CMS' average projected expenditures for Medicaid enrollees. Approximately 60% of the SFY 2014 prior-eligible enrollment is children who will receive a 100% federal funds match. As discussed in Section 1, it is important to note that Kentucky likely would have incurred the cost of the prior-eligible members regardless of the decision to expand Medicaid, similar to the experience of other non-expansion states.

Figure 12. Updated Estimate of Expenditures for Prior-Eligible Population, SFY 2014-2021



Additional administrative costs anticipated for Medicaid expansion have not been included in the state's biennial budget. The 2013 Whitepaper estimated increased administrative costs for the additional membership, along with the changes required to implement the new program. These increases ranged from $6.1 million in SFY 2014 to $11.7 million per year from SFY 2017 to SFY 2021. While costs may be incurred, the current biennial budget does not include additional funding for administrative costs for Medicaid expansion, so administrative costs have not been included in this analysis.

Job Creation

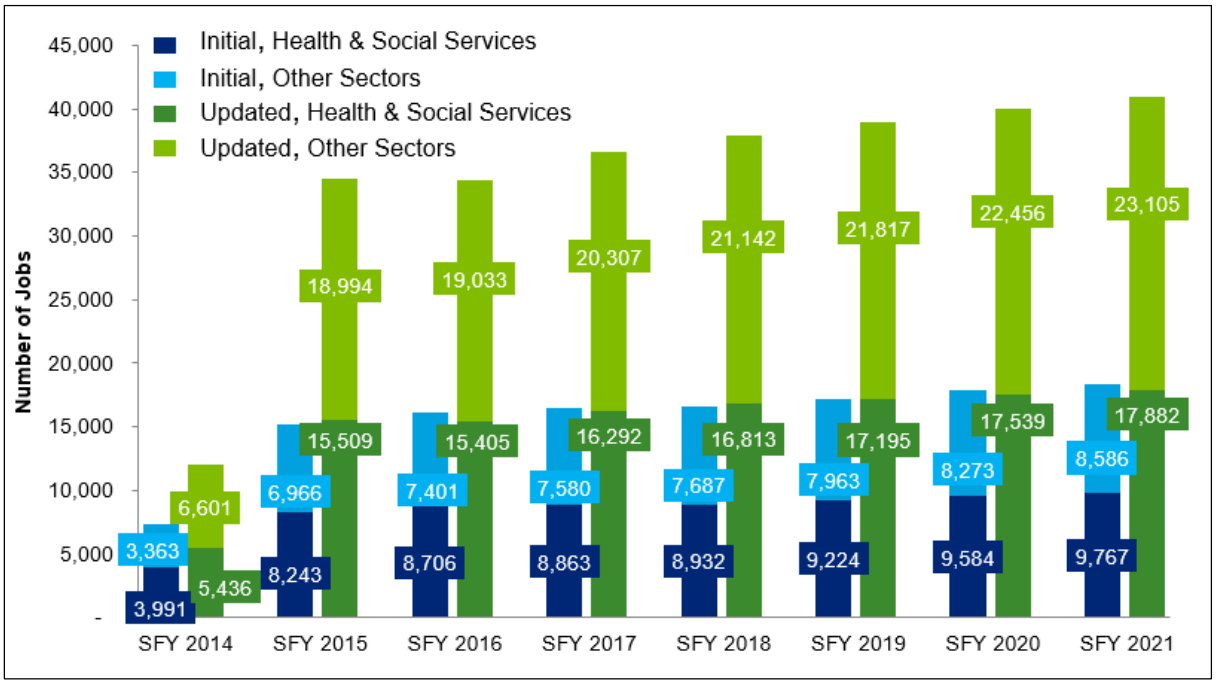
According to economic modeling by USI, Medicaid expansion has led to an estimated increase of more than 12,000 jobs in SFY 2014, exceeding the original first-year estimate by nearly 50%. Medicaid expansion is estimated to result in the addition of more than 40,000 jobs by the end of SFY 2021, exceeding the original estimate by more than 140%. The economic impact of job creation was a benefit cited to support Medicaid expansion in the 2013 Whitepaper, which concluded that Medicaid expansion presented a major, market-driven economic stimulus for Kentucky. As new Medicaid beneficiaries are empowered to obtain the health care they need, doctors and other health care professionals are able to provide care to newly eligible individuals knowing that their patients have access to health insurance through Medicaid.

In the 2013 Whitepaper, USI conducted an analysis to estimate Medicaid expansion's impact on job creation in the Commonwealth. In its analysis, USI used an economic input-output model based on data

from the United States Bureau of Labor Statistics (BLS) to derive job creation estimates. This model derived its outputs using the economic multiplier effect measuring the impact of a dollar spent as it flows through different sectors of the economy. In this scenario, the output of the model represents the direct, indirect, and induced effects of Medicaid expansion in Kentucky. The 2013 Whitepaper projected that Medicaid expansion would result in an additional 17,000 cross-industry jobs for Kentucky through SFY 2021.

With a year of experience, CHFS requested that USI update its analysis based on SFY 2014 data and updated enrollment estimates, in order to analyze the impact that Medicaid expansion had on state unemployment and job creation in SFY 2014. Figure 13 displays USI's initial and updated estimate of the number of jobs that may be created from Medicaid expansion expenditures in Kentucky.

Figure 13. Updated Estimate of Jobs Created from Medicaid Expansion Expenditures, SFY 2014-2021



This update indicates that Medicaid expansion has led to significant job creation for Kentucky in SFY 2014 and will continue to lead to job growth in future years. The USI estimates show that more than 12,000 jobs were created in SFY 2014, with more than 5,400 of those jobs created in the Health & Social Services sector. These results are consistent with the results from BLS, which show that seasonally adjusted health care and social assistance jobs increased by 5,300 from November 2013 to November 2014 (United States Department of Labor: Bureau of Labor Statistics, 2015).

The jobs created from Medicaid expansion will impact more than just the health care sector. In fact, the updated estimate shows that by SFY 2021, just 44% of new jobs will come from the Health & Social Services economic sector. The majority of jobs will be created in other economic sectors.

Comparing Kentucky's state unemployment rate to the U.S. rate also shows signs of economic recovery since Medicaid expansion began. From January 2011 to November 2014, Kentucky's unemployment rate exceeded the U.S. rate. Beginning in January 2014, that gap has narrowed significantly. Kentucky's unemployment rate was 7.7% in January 2014 compared to a U.S.

unemployment rate of 6.6% during the same time period, a difference of 1.1 percentage points. By November 2014 the gap narrowed to just 0.20% (United States Department of Labor: Bureau of Labor Statistics, 2015). In fact, in August, September, and October 2014, unemployment rates dropped in every county in Kentucky; the first time this has occurred since unemployment records have been maintained (United States Department of Labor: Bureau of Labor Statistics, 2015). While many factors contributed to the recovery, this data indicates the economy of Kentucky improved at a faster rate than the overall U.S. economy in CY 2014, which was the first year of Medicaid expansion. The data available does not conclude there is a causal relationship between CY 2014 economic growth and Medicaid expansion, but instead offers a correlation between the two events.

Improvements in statewide employment will also have a positive fiscal effect on the Kentucky Medicaid program. Like the traditional Medicaid program, Medicaid expansion enrollment is inversely correlated with economic well-being in the state; enrollment growth should decline as Kentucky's economy continues to grow. Individuals in the Medicaid expansion population who become employed or begin to earn higher wages become more likely to transition out of the Medicaid program and obtain other forms of health insurance. For example, Qualified Health Plans (QHP) offered through kynect are a viable option for Medicaid expansion enrollees to transition out of the program, especially when combined with cost-sharing subsidies that incentivize individuals to purchase an insurance plan offered through the commercial marketplace. This analysis does not attempt to quantify the effect of improvements to statewide unemployment on the budget.

The increase in jobs resulting from the decision to expand Medicaid has materially impacted the Kentucky economy and the state budget. According to the USI, the Kentucky Medicaid expansion is expected to result in an additional 40,000 jobs, with an average salary of $41,000, throughout the state and raise more than $1 billion through a combination of state income taxes, state sales taxes, and occupational and payroll taxes from SFY 2014 to SFY 2021.

Table 11. Estimated State and Local Revenue Impacts of Medicaid Expansion

SFY	State Income Taxes	State Sales Taxes	Local Occupational & Payroll Taxes	Total
2014	$19,300,000	$18,130,000	$6,264,000	**$43,694,000**
2015	$56,317,000	$52,903,000	$18,279,000	**$127,499,000**
2016	$57,220,000	$53,751,000	$18,572,000	**$129,543,000**
2017	$61,905,000	$58,152,000	$20,092,000	**$140,149,000**
2018	$65,353,000	$61,391,000	$21,211,000	**$147,955,000**
2019	$68,378,000	$64,232,000	$22,193,000	**$154,803,000**
2020	$71,360,000	$67,034,000	$23,161,000	**$161,555,000**
2021	$74,442,000	$69,929,000	$24,161,000	**$168,532,000**
Total	**$474,275,000**	**$445,522,000**	**$153,933,000**	**$1,073,730,000**

Managed Care Rates

According to Kentucky's Medicaid actuary, Aon Consulting, SFY 2014 experience shows that the Medicaid expansion population is less costly than estimated in the original rates. Experience data for the Medicaid expansion population was not available when the SFY 2014 rates paid to MCOs were determined. As such, SFY 2014 managed care capitation rates were estimated based on the experience of similar populations, rather than specific population data. This required Kentucky and other expansion states to develop Medicaid managed care rates for the expansion group based on existing actuarially approved rates for Medicaid populations similar to the new Medicaid expansion population. Kentucky used its experience with the previously income-eligible adult category.[10] This group is the traditional eligibility group most similar to the expansion population. Kentucky's Medicaid actuary used this rate and applied a multiplier to account for anticipated pent-up demand that could lead to increased utilization of services for these new members, particularly in the first years of expansion.

Now that Kentucky has a year of experience with the Medicaid expansion population, the state's actuary can better estimate future rates for this group. Consequently, in view of first-year data, Kentucky intends to reduce SFY 2016 rates for the Medicaid expansion population from those used in SFY 2014 and SFY 2015. This decrease in rates means lower costs per enrollee for Kentucky when the state starts to pay a portion of the Medicaid expansion cost starting in CY 2017.[11]

Kentucky's first-year experience parallels the national experience as reported in a CMS Office of the Actuary analysis. In that report, CMS projects that expenditures for the Medicaid expansion population will decrease from FFY 2014 to 2015 and again in FFY 2016 (Office of the Actuary, CMS, HHS, 2013).

[10] Historically, Medicaid in Kentucky included elderly, disabled, children, pregnant women, and/or parents. The previously income-eligible adults group includes a subgroup of traditional Medicaid comprised of very low-income parents and caretaker relatives, who are most similar to the Medicaid expansion population for comparative purposes.

[11] As part of the rate approval process, CMS placed certain requirements on the estimated rates used for the expansion population. As a result, CMS will recoup excess payments from MCOs, further reducing financial risk to the state.

III. Additional Economic Considerations

Kentucky's decision to expand Medicaid has positively impacted the economy of the state, including direct effects to the health care system and positive impacts on the health of Kentuckians. USI used the average monthly enrollment and Medicaid expenditure estimates to derive the private sector impacts attributable to Medicaid expansion. IMPLAN, an economic input-output model, was the software chosen for the estimation. This model has been a staple in many tax increment financing (TIF) and tax deferred annuity (TDA) project reports over the past decade, as it measures the impact of increases in one sector across other sectors in the economy.

This model estimates the following impacts from Medicaid expansion from SFY 2014 to SFY 2021:

- **$20 billion in payments to health care providers.** Nearly all of this is federal payments to providers; however, beginning in SFY 2017, Kentucky will be responsible for the state share portion of these payments.
- **The creation of more than 12,000 jobs in SFY 2014 as a result of Medicaid expansion.** By SFY 2021, this number is expected to grow to approximately 40,000 jobs. The wages and salaries for these jobs, net of non-taxable benefits, are expected to exceed $11.3 billion.

Table 12. Estimated Impacts of Medicaid Expansion on Provider Payments and Employment, SFY 2014-2021

Provider Payments	
Hospitals	$9,270,325,000
Pharmacies	$5,072,655,000
Primary Care	$3,667,440,000
Other Providers	$1,986,268,000
Total Payments to Providers	**$19,996,688,000**
Employment	
Health Care and Social Services	17,882
Other Sectors	23,316
Total Jobs Created	**40,987**
Average Salary	$41,000
Payroll Estimate (net of non-taxable benefits)[12]	$11,300,259,000

[12] Because the average salary is an average over the full SFY 2014 to SFY 2021 period and the number of jobs will increase over this time, the payroll estimate cannot be calculated by a multiplication of the total jobs created and the average salary. Instead, it must use the salary outputs from the model that align with jobs created for each year.

Direct spending on health care also causes indirect and induced spending to occur. Examples of the indirect effects of Medicaid expansion include the additional goods and services being purchased by hospitals, pharmacies, and doctors' offices from other businesses in Kentucky to accommodate the increased demand for health care services. Induced effects also arise from the household spending of new employees that are hired by businesses affected by the increased demand for their products and services.

Cumulatively, Kentucky's total economic impact from Medicaid expansion between SFY 2014 and SFY 2021 is estimated to be $30.1 billion. The net cumulative fiscal impact to Kentucky is estimated to be $819.6 million by the end of SFY 2021. It should be noted that the model used to estimate the economic impact does not include the potential additional corporate tax revenue or additional property taxes.[13]

Table 13. Estimated Economic Impacts of Medicaid Expansion, SFY 2014-2021

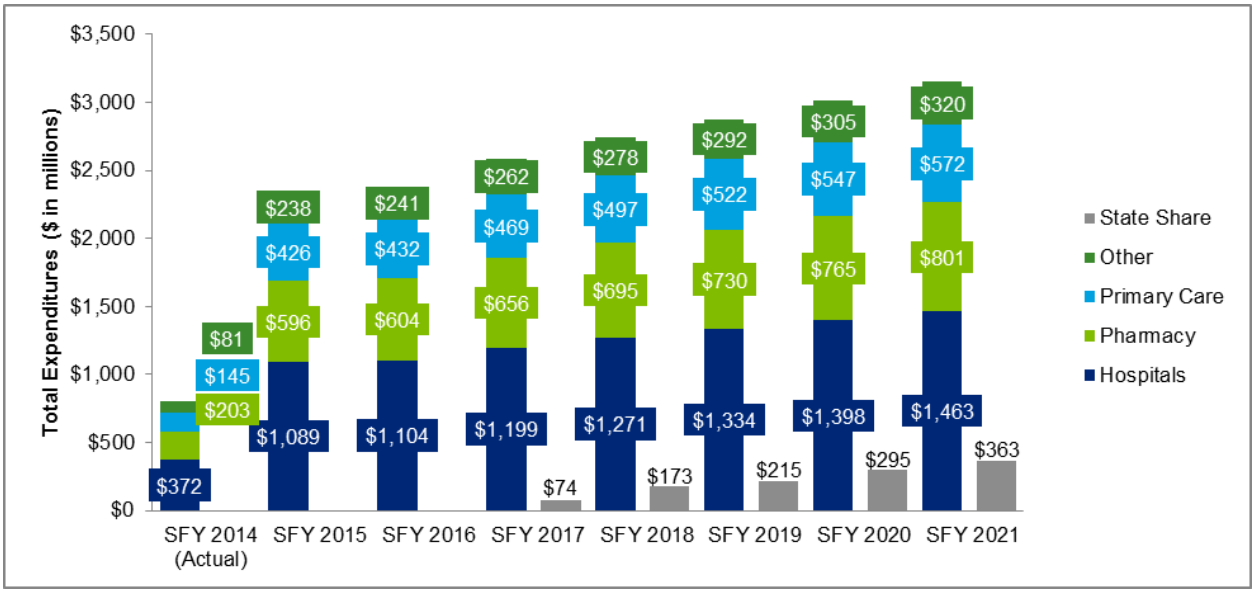
Economic Impact	
Total Economic Impact to the State	$30,083,438,105
Net Cumulative Fiscal Impact to Kentucky	$819,618,000

Increased Revenue to Providers

Kentucky's Medicaid expansion led the provider community to experience a significant increase in revenue in CY 2014 through direct services, supplemental payments, and DSH payments. Hospitals and physicians across the state have reported increases in CY 2014 revenues. Figure 14, which follows, represents the initial and estimated reimbursement to Medicaid provider types through SFY 2021. Beginning in January of SFY 2017, when the 100% federal match rate begins to decrease, General Fund expenditures represent a small proportion of overall reimbursement to providers. By the end of SFY 2021, total provider reimbursement for Medicaid expansion is estimated to be $3.2 billion – the state's share of this reimbursement is expected to be $363 million, just 11% of the reimbursement to providers. Hospitals will continue to receive the majority of these payments, followed by pharmacy and primary care providers.

[13] According to USI, it could be argued that a $20.0 billion investment in the health care sector and $30.1 billion economic impact will also result in increased corporate tax revenue or additional property taxes; however, those were not included in the model. Property taxes would be a secondary effect, and the corporate tax structure is more difficult to model than sales, income, and occupational taxes. The revenues accumulating to MCOs were also excluded from the economic and tax analysis. The primary reason for this exclusion is the complex nature of multi-state insurance companies as well as the tax status of some MCOs. It is not feasible to estimate the share of overhead at each company allocated to Kentucky employees or the revenue distribution between for-profit and not-for profit organizations.

Figure 14. Estimated Increase in Provider Revenues Relative to State Expenditures, SFY 2014-2021



Provider revenue for both Medicaid expansion and traditional Medicaid in Kentucky grew by more than 26% or $1.3 billion from CY 2013 to CY 2014, aligning with the first year of Medicaid expansion. Nearly all provider types[14] experienced Medicaid revenue growth from CY 2013 to CY 2014 (detailed in Table 27 of the Appendix). Pharmacies and primary care providers saw the largest growth in revenue (58% and 52% respectively), while hospitals, which have the largest nominal revenue share, experienced growth of about 27%. The increased growth of primary care relative to hospital care suggests that revenue from expansion members is being directed more heavily toward less costly services. Moreover, provider revenue (both direct payments and supplemental payments) attributed directly to Medicaid expansion totaled $1.16 billion in CY 2014, as shown in Table 14 on the following page (payments to providers by county for Medicaid expansion members by member county and by provider county can be found in Tables 28 and 29 of the Appendix, respectively).

[14] With the exception of Intermediate Care Facilities of Intellectually and Developmentally Disabled (ICF/IDD).

Table 14. Expansion Revenue by Provider Type, CY 2014

Provider Type	% of Total Revenue from Expansion	Total $ Amount Paid from Expansion
Hospital	43.6%	$506,561,000
Pharmacy	21.0%	$243,579,000
Primary Care	21.1%	$245,853,000
Other	9.1%	$106,172,000
Medical Equipment	2.6%	$30,732,000
Dental	1.6%	$18,075,000
Behavioral Health Services	1.0%	$11,836,000
Total	**100.0%**	**$1,162,808,000**

In addition to direct service payments to providers, four providers received supplemental payments for expansion members (in addition to those for traditional members) to bring their Medicaid payment rates to Medicare-equivalent levels. The additional supplemental payments resulting from expansion totaled more than $88 million in CY 2014. These supplemental payments are 100% federally funded for expansion for CYs 2014, 2015, and 2016; the state will begin to contribute 5% in CY 2017, gradually increasing to 10% in CY 2020.[15]

Table 15. Expansion Supplemental Payments, CY 2014

Institution	Total Amount Paid
University of Kentucky	$39,729,000
University of Louisville	$39,604,000
Appalachian Regional Healthcare	$1,710,000
Kosair Children's Hospital	$7,766,000
Total	**$88,809,000**

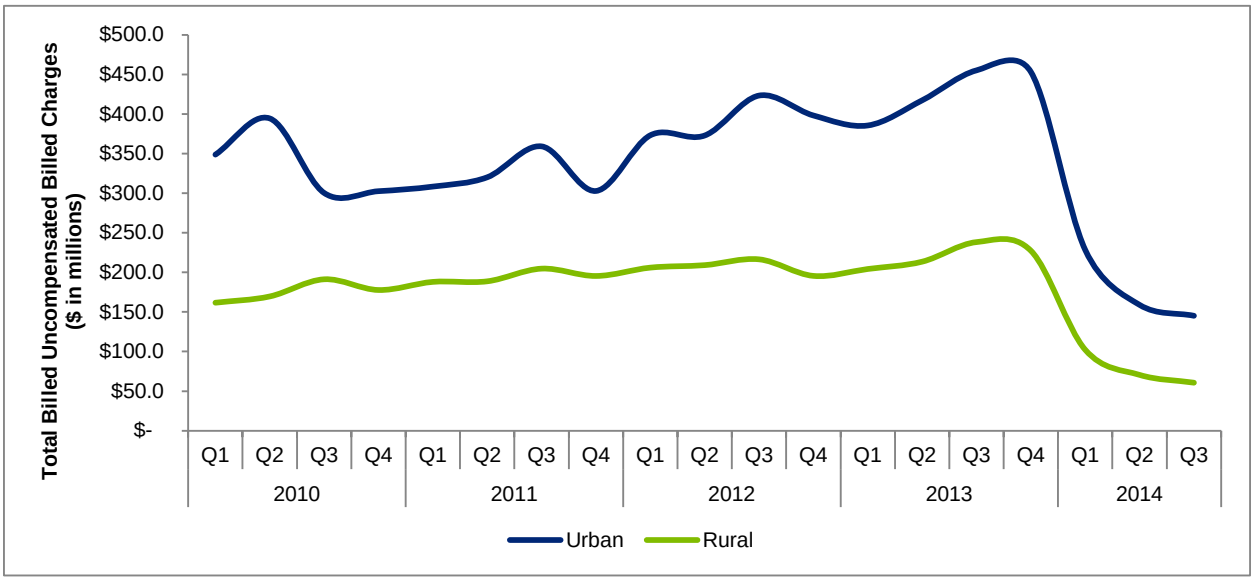
[15] The University of Kentucky and the University of Louisville pay the state share for supplemental payments.

Reductions in Uncompensated Care

Based on initial data, uncompensated care charges appear to be decreasing in Kentucky, consistent with national projections. An important reason for insuring individuals is to reduce the costs that are shouldered by the insured population (via increasing premiums and costs) due to uncompensated care provided to the uninsured. In September 2014, the U.S. Department of Health and Human Services (HHS) released a report that projected a decrease in uncompensated care costs of approximately $5.7 billion in CY 2014 nationwide as a result of reductions in the uninsured population due to Medicaid expansion. HHS estimates indicate 74% of the savings, or roughly $4.2 billion, will be recognized by states that chose to expand Medicaid, while the remaining 26%, or $1.5 billion, will be saved by states that chose not to expand Medicaid. In this report, HHS notes that the volume of emergency visits and admissions for self-pay individuals, which comprise a majority of uncompensated care provided by hospitals, has declined substantially for Medicaid expansion states, while the volume of self-pay emergency visits and admissions have remained flat in non-Medicaid expansion states (DeLeire, Joynt, & McDonald, 2014).

Uncompensated care charges have been on the decline since the start of Medicaid expansion based on analysis of uncompensated care data provided by the Kentucky Hospital Association (KHA) for the period CY 2010 through third quarter CY 2014. Figure 15 shows the change in total uncompensated care billed charges in both rural and urban hospitals. During the first three quarters of CY 2013, uncompensated billed charges totaled $1.9 billion. However, in the first three quarters of CY 2014 when Medicaid expansion began in Kentucky, uncompensated charges totaled $766 million – a decrease of $1.15 billion (detailed uncompensated care comparisons between CY 2013 and CY 2014 are provided in Table 33 in the Appendix). This decrease is evident in both urban and rural hospitals. This may be an effect of increased access to health insurance from Medicaid expansion and kynect, which generally reduces uncompensated charges.

Figure 15. Total Billed Charges for Uncompensated Care – Rural and Urban



Improving the Health of Kentuckians

The economic model used to estimate the fiscal impact to the Commonwealth is conservative in that it does not account for a number of variables that could result in increased net benefits to the state and its residents. For example, the CMS enrollment estimates and USI economic model used in this report estimate that Kentucky experienced static employment levels and do not explicitly incorporate increased employment and a declining unemployment rate, which would likely result in lower future Medicaid enrollment. Thus, it is reasonable to assume that increasing employment may bend the Medicaid expansion enrollment curve downward in future years. Similarly, the model does not account for the avoidance of ACA employer tax penalties, which Medicaid expansion offers. A January 2014 analysis estimated the additional tax penalties that could impact large employers in non-expansion states, as well as the potential tax penalties avoided in states that chose to expand. Based on that analysis, Kentucky employers are likely to experience $28 to $42 million less in tax penalties per year than they would have experienced without Medicaid expansion (Haile & Brandes, 2014).

Additionally, the fiscal analysis does not incorporate the potential for cost savings experienced through improved health of Kentuckians. ACA provides previously uninsured individuals a ready payer source, enabling improved access to primary care and preventive services. The increased use of primary care and preventive services has the potential to help address the state's substandard health statistics on measures such as tobacco use, obesity, cancer, heart disease, and oral and behavioral health (Office of Governor of Kentucky Steve Beshear, 2014).[16]

Kentucky's substandard chronic disease rates impose a significant economic burden on Kentuckians and the state. Examples of costs attributable to health conditions include the following:

- According to the Centers for Disease Control and Prevention (CDC), nationwide, tobacco use costs the U.S. more than $289 billion a year (Centers for Disease Control and Prevention, n.d.).
- The CDC reported that the estimated annual medical cost of obesity in the U.S. was $147 billion in 2008 dollars; the medical costs for people who are obese were $1,429 higher than those of normal weight (Centers for Disease Control and Prevention, n.d.).
- Cancer annual medical costs in 2010 were estimated to be $2.23 billion in Kentucky (estimated to increase by 69% by 2020 to approximately $3.78 billion) (Kentucky Cancer Consortium, July 2013).
- Heart disease generates $273 billion in annual medical costs nationwide and is estimated to rise to $818 billion by 2030 (American Heart Association, 2011).
- The Kentucky Office of Drug Control Policy estimates that the costs of productivity loss, health care, and drug-related crime related to drug abuse range from $2.5 to $3.6 billion annually (Kentucky League of Cities, n.d.).

[16] In addition to reducing the state's uninsured rate, Governor Beshear identified these six focus areas in his kyhealthnow initiative, in which he identified improvement goals for each area over a five-year period ending in 2019.

Considerable research supports the theory that improved population health via reduced rates of chronic disease can result in economic benefits. For example, an April 2012 report from the Institute of Medicine (IOM) found that the indirect costs associated with preventable chronic diseases – costs related to worker productivity as well as the resulting negative fiscal impact on the nation's economic output – may exceed $1 trillion per year (Harvard School of Public Health, 2012).

While the fiscal and economic impacts of Medicaid expansion are important, it is also important to consider the social and population health benefits of expanding the availability of health insurance. Numerous research studies have reported that increasing access to quality health care coverage has been linked to improvement in population health outcomes. The positive correlation between population health and increased access to affordable coverage is discussed extensively in academic literature, with Massachusetts being a commonly studied state.

An article in the *Annals of Internal Medicine* found that health reform in Massachusetts was associated with "significant reductions in all-cause mortality and deaths from causes amenable to health care." (Sommers, M.D., Long, PhD, & Baicker, PhD, 2014). This is in line with a 2012 *New England Journal of Medicine* study which reported a significant reduction in mortality in the states that implemented expansions in adult Medicaid eligibility in comparison with neighboring states without expansions (Baicker, Ph.D., Sommers, M.D., & Epstein, M.D., 2012). Given Kentucky's significant increase in coverage, it may be poised to experience similar health improvements.

Medicaid expansion offers an opportunity for access that could help contribute to these economic, social, and population health benefits. However, it is important to note that Medicaid expansion alone likely will not lead to these savings, but instead these savings require significant policy and behavior changes. Analysis of the first year of claims data, as described in the next section, begins to offer a picture of how the Medicaid expansion population is behaving and accessing care, which may begin to indicate the potential for realizing these savings, as well as social and population health benefits.

IV. An Early Assessment of the Medicaid Expansion Population

From the inception of Medicaid expansion on January 1, 2014 through December 31, 2014, the Commonwealth has added 375,175 Kentuckians to its Medicaid program. Studying the newly enrolled Medicaid population provides the opportunity to understand the demographic traits and health status of the population. This information can be used to anticipate future health care spending, utilization, and needs as additional uninsured Kentuckians enroll in Medicaid under ACA.

This study used historical information from the previously income-eligible adult population to analyze the Medicaid expansion population. The Medicaid expansion population is defined as individuals newly eligible for Medicaid as a result of the Commonwealth's decision to expand Medicaid for households earning below 138% of the FPL. As discussed earlier, traditional Medicaid did not cover all persons below the FPL; accordingly, newly eligible individuals often include low-income childless adults and the "working poor" who did not previously qualify for Medicaid.

Since the state lacks access to historical data for the Medicaid expansion population, this analysis uses a group within the traditional Medicaid population most similar to the Medicaid expansion group – previously income-eligible adults (hereafter referred to as the "comparative group") – for comparisons. These are adults with children and caretakers who meet certain income thresholds as a percentage of the FPL, based on household size. Similar to the Medicaid expansion group, the comparative group includes low-income adults and is therefore a relevant population for comparison. Moreover, this eligibility group was often examined to understand health care behaviors and costs during Kentucky's planning for Medicaid expansion, as discussed in this report's section on managed care rates.

Using this group for comparison is helpful to understand the demographics and health status of the Medicaid expansion population, although the comparison is limited somewhat due to differences in age and gender. The following sections share insights into the demographics and health status of the Medicaid expansion population compared to that of the comparative group, where such assessments are appropriate or relevant.

Demographics[17]

Age & Gender

As expected, on average, recipients in the Medicaid expansion population are older than recipients in the comparative group. The average age of the comparative group is 30, whereas the average age of the Medicaid expansion population is 38. While less than 50% of the Medicaid expansion population is between the ages of 18 and 35, more than 70% of the comparative group is in that same age group. The age variation is not unexpected, as the individuals in the comparative group are required to be the primary caretaker of at least one child under 18 in order to be eligible. The number of adult recipients in the comparative group drops considerably as individuals age, with less than 7% of comparative group members being older than 45. For both the comparative group and the Medicaid expansion group, individuals in the 26 to 35 age group make up the largest portion of recipients, about 38% and 27% respectively. The Medicaid expansion group experiences a 7% jump between the 18 to 25 and 26 to 35 age groups.

Medicaid expansion recipients are more evenly distributed between males and females than the comparative group, who are disproportionately female. This observation is consistent with the eligibility criteria for traditional Medicaid adult recipients who must be primary caretakers of low-income children. Figure 16 and Figure 17 on the next page compare the age and gender breakdown of the comparative group and that of the Medicaid expansion population.

As depicted in Figure 16 and Figure 17, nearly 60% of the comparative group is composed of women under age 35. In contrast, the Medicaid expansion population is more evenly distributed across both age and gender. These differences in age and gender indicate that many previously underserved adult populations, including men and older women, are now starting to receive coverage through Medicaid expansion.

[17] Comparisons related to the race and ethnicity of the Medicaid expansion population could not be made since providing race and ethnicity information is optional for Medicaid applicants.

Figure 16. Comparative Population by Age and Gender

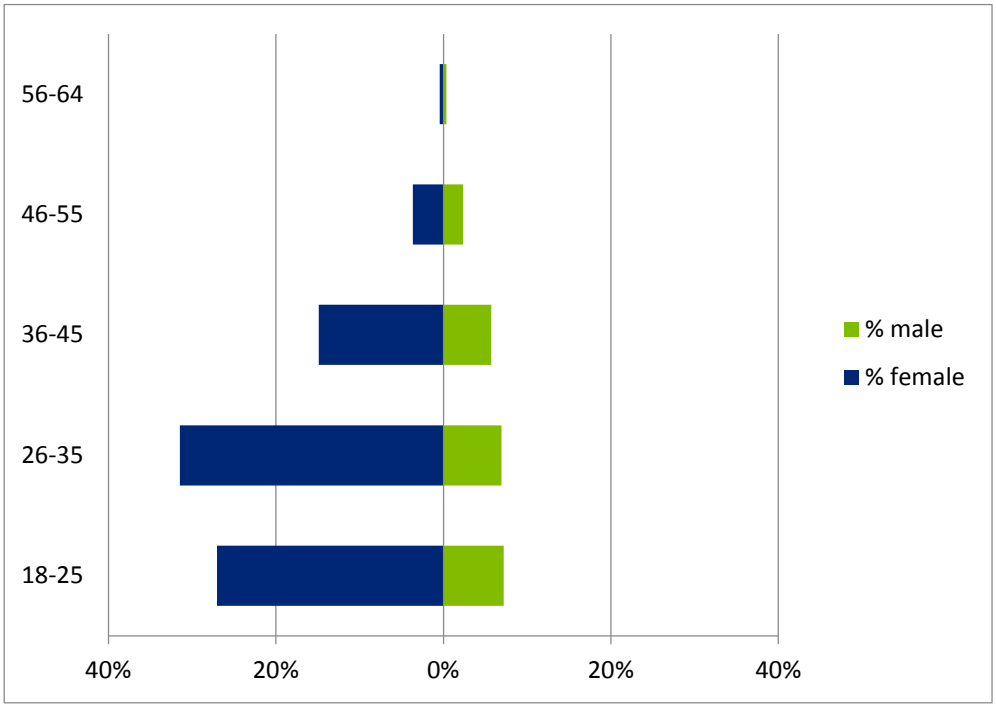
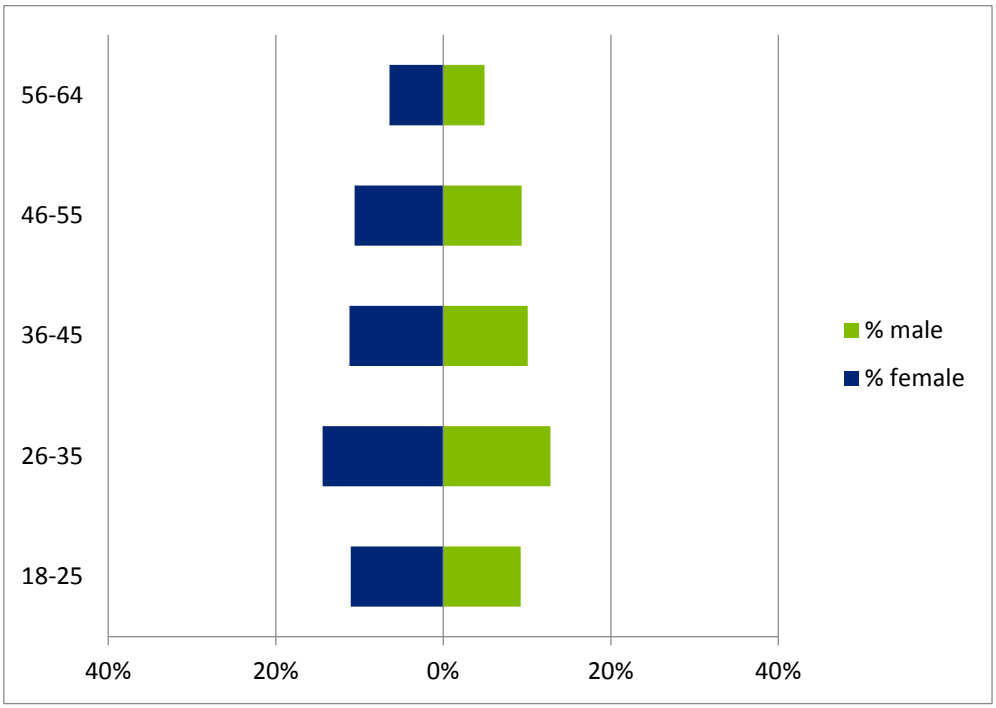


Figure 17. Medicaid Expansion Population by Age and Gender



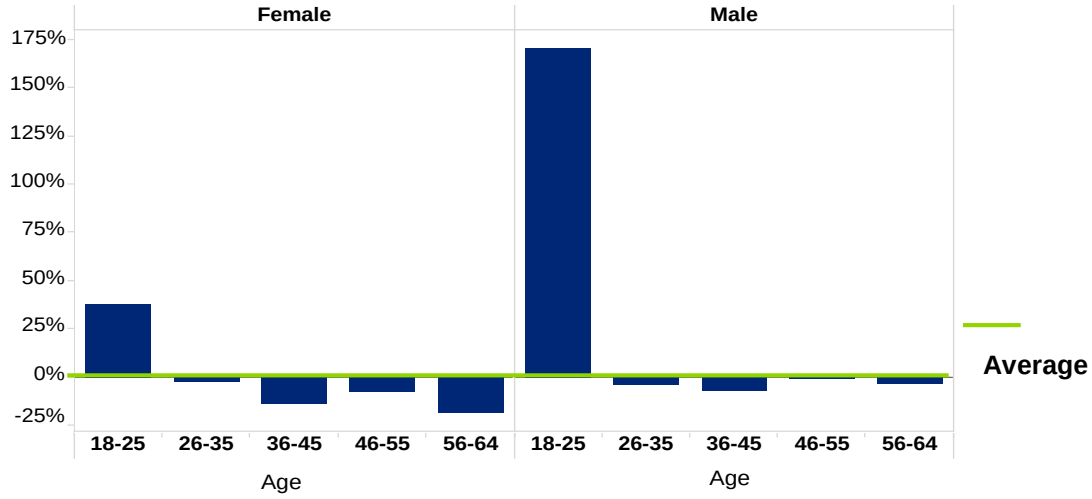
Despite their demographic differences, the average health care costs of the Medicaid expansion population are comparable to the health care costs of the comparative group. The average health care costs of Medicaid expansion recipients are about 1.6% greater than the costs of members in the comparative group, implying that the costs between the populations are level, or perhaps slightly higher,

among Medicaid expansion recipients. This comparison is based on age/gender neutral costs in order to minimize bias in costs related to the age and gender of the populations. For example, members of the comparative group are disproportionately female because of traditional Medicaid eligibility rules that generated more female enrollment than male enrollment. Conversely, the Medicaid expansion population is more demographically diverse across age groups and gender than enrollment in the comparative group, since Medicaid expansion eligibility is based solely on income status. As discussed in the managed care rate section, Kentucky had assumed that costs would be higher for the Medicaid expansion group because of pent-up demand for services. However, data suggests that the Medicaid expansion group's costs are more in line with costs for the comparative group.

When looking at specific age groups, Medicaid expansion members generally have lower claim costs than the comparative group, with the exception of the 18 to 25 age group. In the 18 to 25 age group, Medicaid expansion members had relatively higher claims costs than the comparative group. These higher costs for Medicaid expansion members in the 18 to 25 age group are reflective of the disproportionately low average cost for males ages 18 to 25 in the comparative group. It may also reflect pent-up demand for services within the Medicaid expansion population; a longitudinal study using claims experience over a longer period is required to confirm this hypothesis.

Figure 18 shows the percentage difference in Medicaid expansion average health care costs[18] compared to those of the comparative group across age groups and gender. In the figure, 0% represents the average cost of the comparative group, while the graph values show how the Medicaid expansion per-member-per-month (PMPM) cost is either above or below those of the baseline population. Figure 25 in the Appendix also illustrates health care costs relative to average per capita statewide costs by county for the Medicaid expansion and comparative populations.

Figure 18. Medicaid Expansion vs. Comparative Group – Average PMPM by Age and Gender (percentage difference)



[18] Average costs expressed on a PMPM basis.

Location

The Medicaid expansion population is similarly distributed geographically as the overall Medicaid population throughout the Commonwealth. As previously noted, the Medicaid expansion group is most densely concentrated in southeastern Kentucky counties, where the overall Medicaid population ranges between 40% to more than 60% of the total population.

Figure 19. Per Capita Medicaid Expansion Enrollment

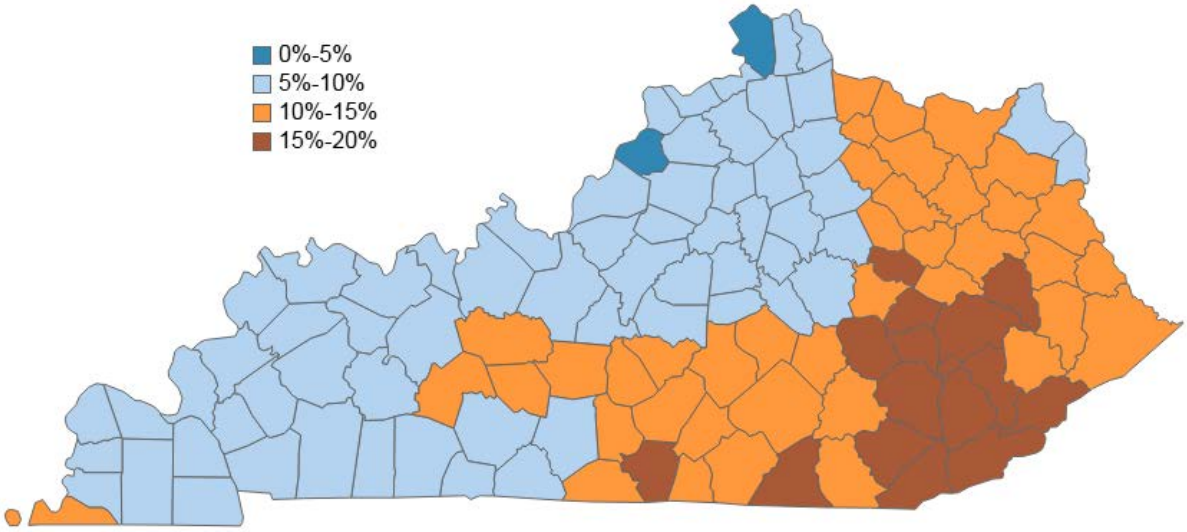
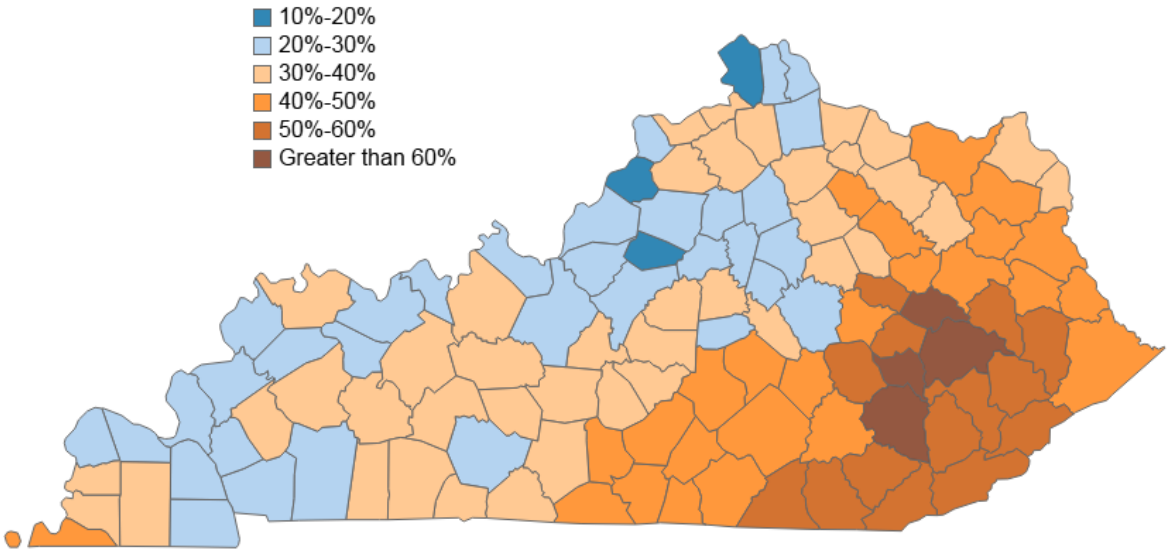


Figure 20. Per Capita Total Medicaid Enrollment



Health Status

Most Common Chronic Conditions Treated

The Medicaid expansion population includes individuals with chronic conditions, which presents long-term cost implications for the Kentucky Medicaid program. It will be important to track the health status of the Medicaid expansion population over time to determine the effects of increased access to care on an individual's health. For example, a study in the *New England Journal of Medicine* determined that the rate of diabetes detection and management increased as a result of the Oregon health experiment, which expanded Medicaid benefits to a portion of Oregon's uninsured population (Baicker, Ph.D., Sommers, M.D., & Epstein, M.D., 2012). While the long-term effects of expansion are still unknown, this section shares findings from first-year Medicaid expansion claims data and provides a foundation for understanding the health needs of the new Medicaid expansion population.

The most common chronic conditions, including hyperlipidemia (high cholesterol) and diabetes, are more prevalent in the Medicaid expansion population than in the comparative group. As shown in Table 16 these chronic conditions were more than twice as prevalent in the Medicaid expansion population. This table highlights age-adjusted and gender-adjusted prevalence rates to allow a consistent comparison of the two populations. These results show that chronic conditions are uniformly more prevalent in the Medicaid expansion population than the comparative group, with similar age and gender characteristics.

While first-year costs for the Medicaid expansion population appear consistent with those of the comparative group, multiple chronic conditions of the Medicaid expansion group may signal a risk of growing health-related problems that may contribute to higher future health care costs for the Medicaid expansion population. With increased access to care, however, it is possible that the prevalence and cost of treating chronic conditions may decrease in the long-term.

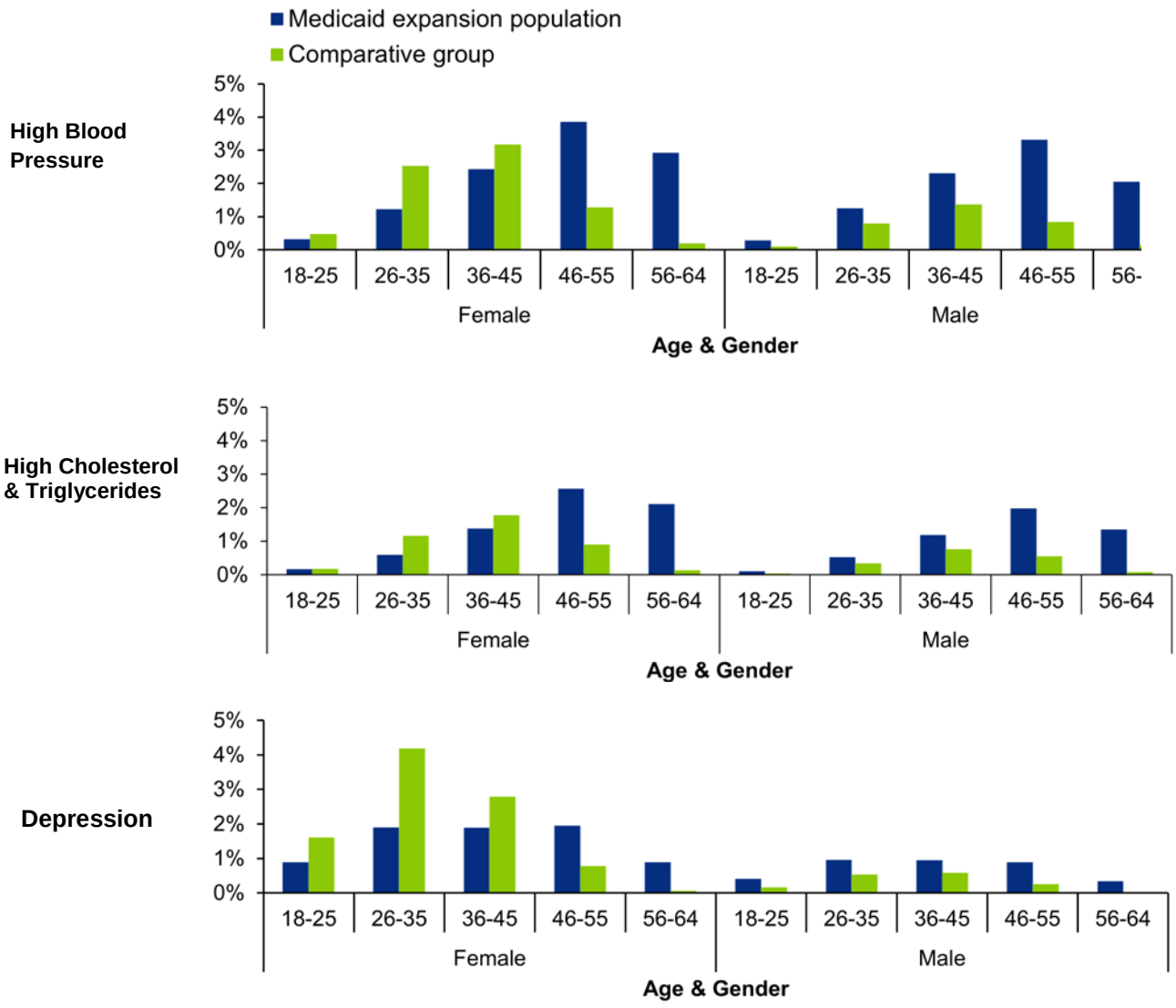
Table 16. Medicaid Expansion vs. Comparative Group – Prevalence of Chronic Condition Treatment (age-adjusted prevalence rates per 1,000 members)

Chronic Condition	Medicaid Expansion*	Comparative Group	% Higher than Comparative Group
High Cholesterol/Triglycerides	2.90	1.35	114.7%
Diabetes	2.02	1.00	102.5%
High Blood Pressure	5.38	2.74	96.5%
Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis	2.40	1.45	65.3%
Asthma	2.41	1.58	52.3%
Depression	5.58	3.89	43.5%

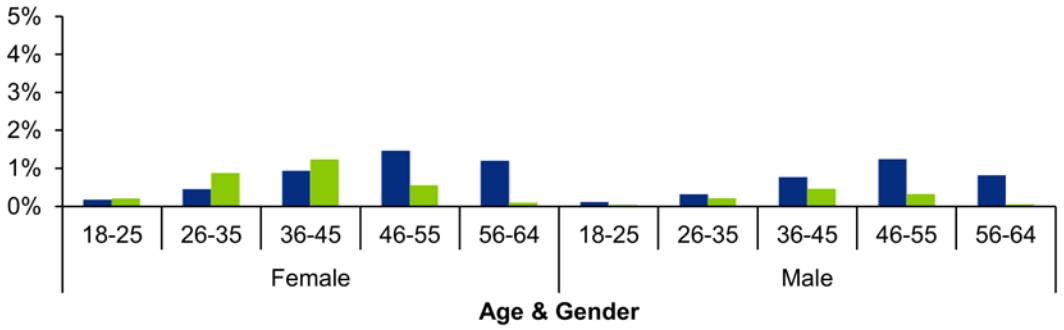
*Age and gender variations held constant to those of the comparative group

Figure 21 compares the most common chronic conditions diagnosed in the Medicaid expansion and comparative group populations among specific age groups and gender (detailed data from Figure 21 is provided in Table 30 in the Appendix). These comparisons show that many common chronic conditions are more prevalent in relatively older, male recipients of the Medicaid expansion population. Conversely, in the comparative group these chronic conditions are more prevalent among younger, female recipients. The older Medicaid expansion population groups are more likely to have a documented diagnosis in claims.

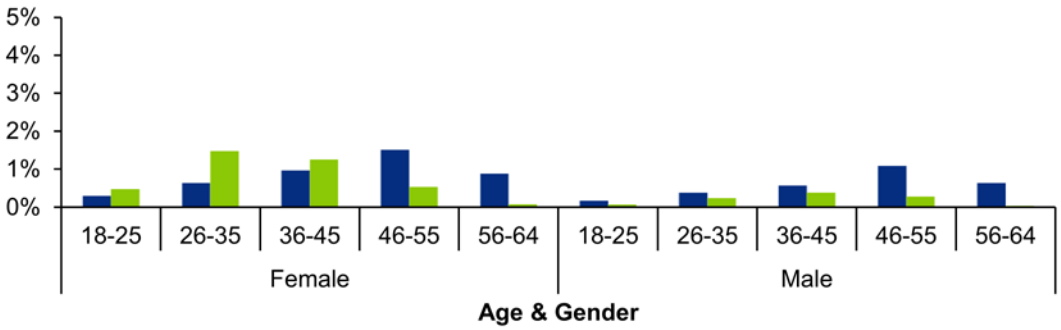
Figure 21. Medicaid Expansion vs. Comparative Group – Most Common Chronic Conditions (percent of population diagnosed)



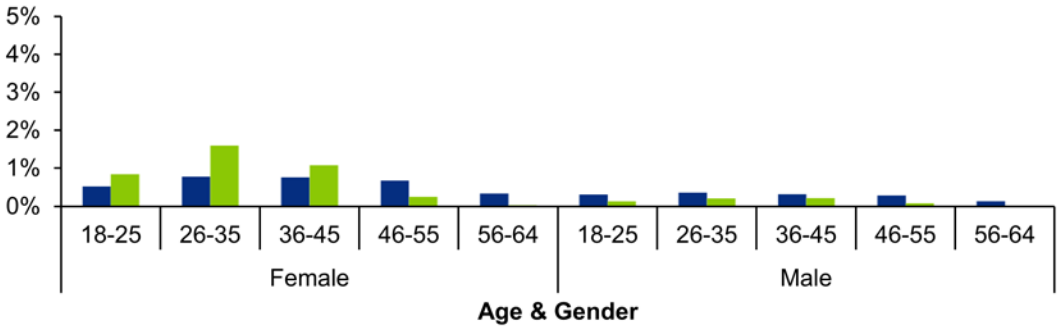
Diabetes



Chronic Obstructive Pulmonary Disease and Bronchiectasis

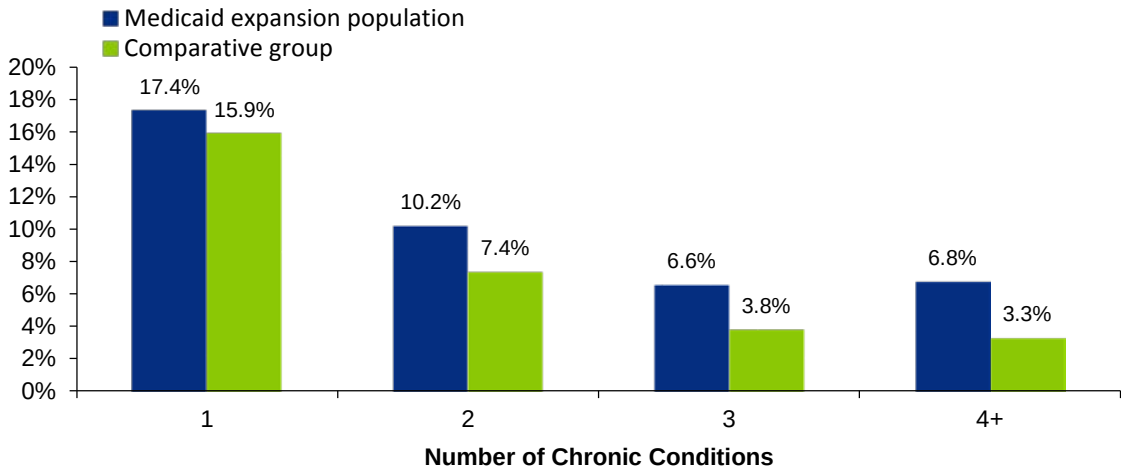


Asthma



The Medicaid expansion population includes a greater percentage of individuals with multiple chronic conditions and is more likely to have a higher prevalence of chronic diseases than the comparative group. As shown in Figure 22, the Medicaid expansion population has a greater share of individuals with chronic conditions, both generally and across a number of chronic conditions. As previously stated, this is likely driven by the older Medicaid expansion population.

Figure 22. Medicaid Expansion vs. Comparative Group – Number of Chronic Conditions (by percent of population diagnosed)



Members with a greater number of chronic conditions enrolled in Medicaid expansion at the start of the program. As projected in the 2013 Whitepaper, individuals with poorer health status were more likely to enroll early in the Medicaid expansion program. For example, 67% of those with four or more chronic conditions who enrolled in Medicaid expansion did so in the first month. In contrast, only 30% of individuals who enrolled in the first year of expansion and had no diagnosed chronic condition enrolled in January 2014. This may indicate that the average number of chronic conditions for the Medicaid expansion population may come down in the future as healthier people enroll.

Most Common Preventive Care Services

Higher utilization of common preventive services reflects that the Medicaid expansion population is seeking out preventive care. Based on CY 2014 claims data, a large portion of Medicaid expansion individuals sought out these services within the first year of Medicaid expansion. Examples of preventive service utilization for the Medicaid expansion population include the following (a full list can be found in Table 32 in the Appendix):

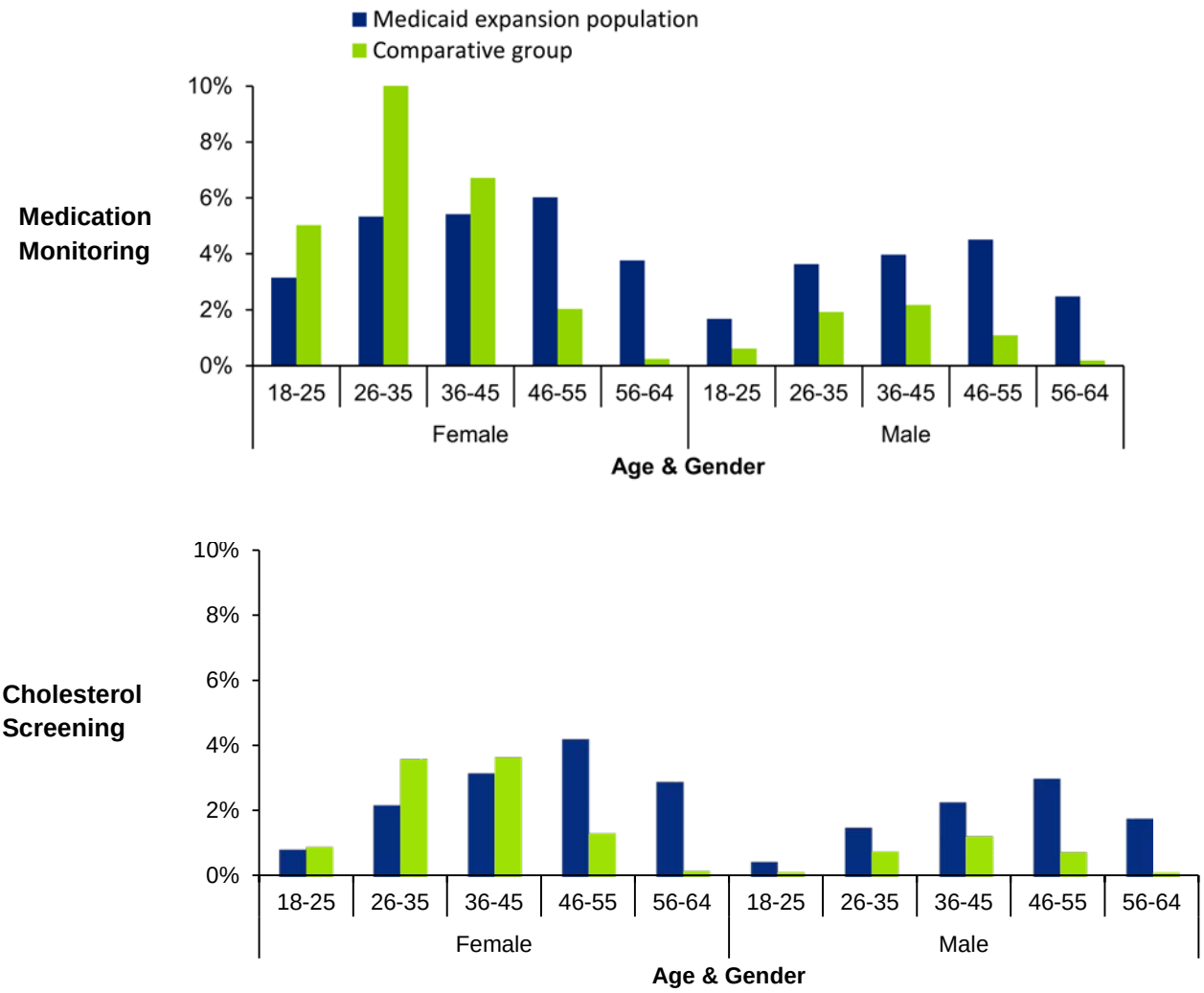
- 232,000 members had a non-annual physician office visit
- 90,000 members received cholesterol screening
- 80,000 members received preventive dental services
- 46,000 members had their hemoglobin A1c test (diabetes screening)
- 34,000 members had cervical cancer screening
- 26,000 members had breast cancer screening
- 17,000 members had colorectal cancer screening

Medication monitoring and cholesterol screenings were two common preventive services provided in CY 2014, for which there is enough data available for both population groups to support utilization comparisons. Both medication monitoring and cholesterol screening services were noticeably more

frequent in the Medicaid expansion population than the comparative group with similar age and gender characteristics. Specifically, medication monitoring services were 74.8% more frequently provided in the Medicaid expansion population, while low-density lipoprotein cholesterol screenings were 115.8% more frequent.

Figure 23 displays these two preventive health care measurements for the Medicaid expansion and comparative group populations by specific age groups and gender. These measurements are comparatively more frequent among male, older recipients in the Medicaid expansion population.

Figure 23. Medicaid Expansion vs. Comparative Group – Most Common Preventive Care Measurements (percent of population using service)



Higher utilization of common preventive care services in the Medicaid expansion population indicates possible pent-up health care demand for first-year enrollees who did not have prior access to preventive care. It is also possible that the Medicaid expansion population, being new to coverage, is receiving a number of screenings typically associated with early visits to providers, while individuals in the comparative group may have received the screenings in the past. Additional claims data in future years will help to validate this trend and determine whether Medicaid expansion individuals will continue to get preventive care treatment over time.

Most Common Provider Types

Based on provider utilization, it can be inferred that the Medicaid expansion population is more actively seeking care for previously unaddressed health needs. For the top three provider types (based on utilization), the Medicaid expansion population is using primary care more than the comparative group at a rate of approximately 55%. Higher utilization of these providers may indicate possible pent-up demand for first-year enrollees under Medicaid expansion, who may have foregone treatment had they not become eligible and enrolled in Medicaid. These individuals may also have sought more expensive care in ERs in the past, rather than care in more appropriate and less costly settings that are covered by Medicaid.

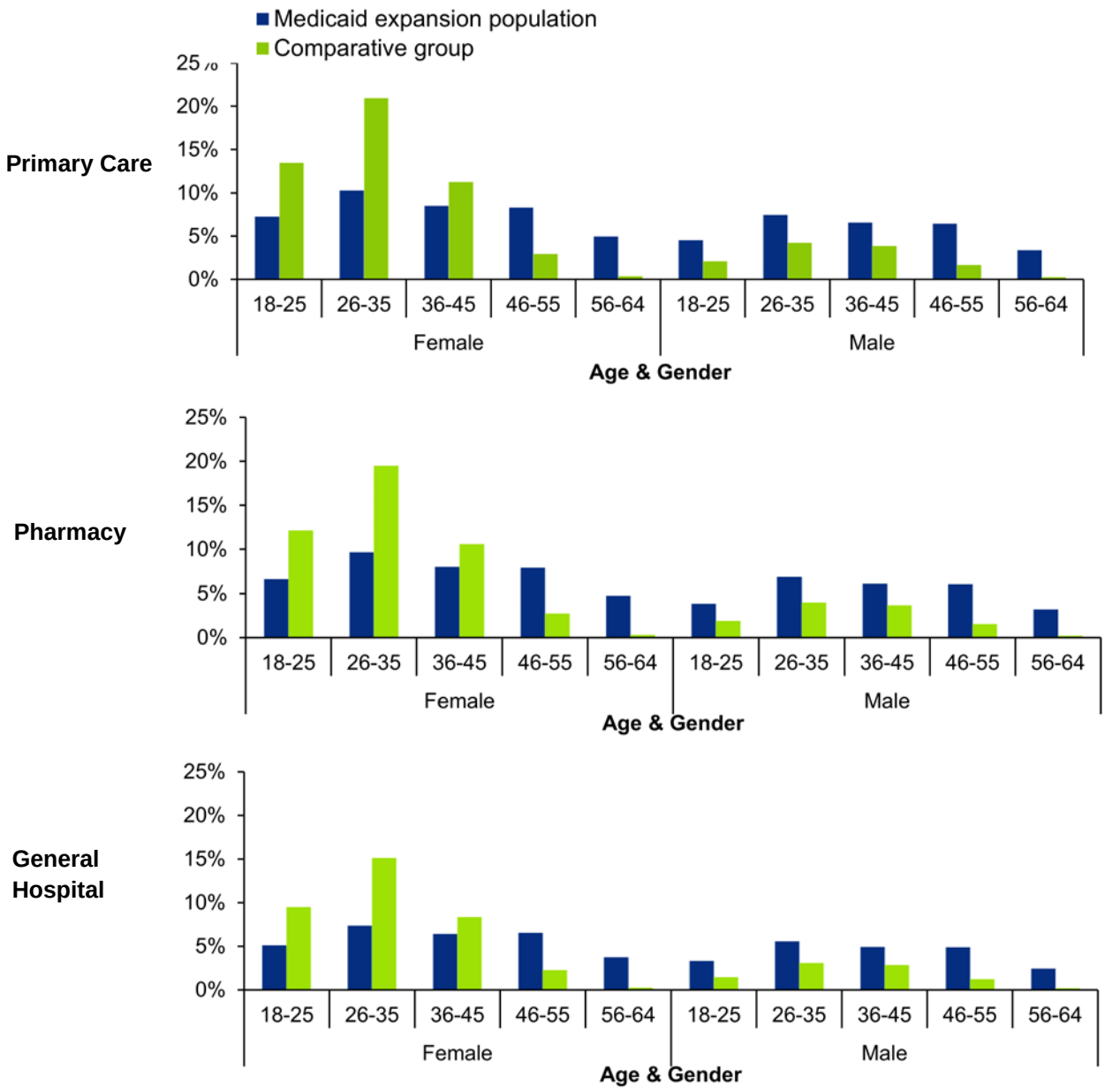
Table 17 illustrates the frequency of primary care, pharmacy, and general hospital utilization by Medicaid expansion recipients relative to the comparative group. Again, results have been normalized for differences in age and gender in order to allow comparisons between the two groups.

Table 17. Medicaid Expansion vs. Comparative Group – Use of Providers (per 1,000 Members)

Provider Type	Medicaid Expansion	Comparative Group	% Higher than the Comparative Group
Primary Care	33.37	21.58	54.6%
Pharmacy	31.04	20.00	55.2%
General Hospital	24.19	15.54	55.6%

The Medicaid expansion population appears to be accessing providers at a higher rate than the comparative group. For each of the three provider types, the Medicaid expansion population experienced higher rates of use when compared to those of the comparative group. There are a number of hypotheses that could explain the variation. Some of these differences could be attributed to age and gender variations. It is also possible that the Medicaid expansion population, being new to coverage, is visiting providers due to previously unmet needs. This data could also document a behavior difference in the two populations. Figure 24, which follows, compares the distribution of providers serving the Medicaid expansion versus the comparative group populations. The fact that more of the Medicaid expansion recipients are visiting these providers appears to support that Medicaid expansion is giving the previously uninsured increased access.

Figure 24. Medicaid Expansion vs. Comparative Group – Most Common Provider Types (percent of population using provider)



ACA's provisions regarding essential health benefits have begun to influence the mix of enrolled Medicaid providers in Kentucky. As part of changes required to implement Medicaid expansion, Kentucky expanded its provider base to include a range of behavioral health providers and also allowed therapists to enroll in Medicaid as independent providers. Table 18 documents the addition of these new providers in CY 2014.

Table 18. Newly Enrolled Medicaid Provider Types, CY 2012 vs. 2014[19]

Provider Type	Number of Providers (2012)	Number of Providers (2014)	Change	% Change
Occupational Therapist	16	45	29	181.3%
Psychologist	31	69	38	122.6%
Licensed Clinical Social Worker	44	83	39	88.6%
Physical Therapist	133	216	83	62.4%
Licensed Professional Clinical Counselor	0	57	57	N/A
Behavioral Health Multi-Specialty Group	0	48	48	N/A
Licensed Marriage and Family Therapist	0	24	24	N/A
Speech-Language Pathologist	0	16	16	N/A
Licensed Psychological Practitioner	0	3	3	N/A

These results are directly attributable to establishing new mental health and substance use disorder benefits for the Medicaid-eligible population as one of the 10 essential health benefits required by ACA. The number of occupational therapists, physical therapists, and speech-language pathologists seeing Medicaid patients also increased a considerable amount in CY 2014. Kentucky now allows these therapists to enroll independently to serve the needs of Medicaid members.

Both Medicaid expansion and comparative group members began receiving these new substance use disorder benefits in CY 2014. Table 19 on the next page identifies the major service categories associated with substance use disorder treatment. In CY 2014, at least 13,000 Medicaid expansion members sought treatment for a substance use diagnosis under the newly added benefits.

[19] This comparison is restricted to providers who have a facility or office address located in Kentucky and received a payment from the state Medicaid program for a Medicaid patient.

Table 19. Total Members with Substance Use Diagnoses who Received a New Benefit, CY 2014

Service Category	Medicaid Expansion	Comparative Group
Crisis Services	110	45
Intensive Community Services	142	48
Outpatient Therapy	3,217	1,721
Peer Support	30	27
Residential	40	7
Screening and Assessment	1,799	747
Other	12,787	4,969

Other provider types also experienced an increase in enrollment that coincides with the increase in Medicaid enrollment. Table 20 shows the seven provider types (other than behavioral health and therapy providers) experiencing the largest increase in volumes from CY 2012 to CY 2014.

Table 20. Additions to Existing Medicaid Provider Types, CY 2012 vs. 2014[20]

Provider Type	Number of Providers (2012)	Number of Providers (2014)	Change	% Change
Nurse Anesthetist	525	646	121	23.0%
Rural Health Clinic	126	150	24	19.0%
Dental – Group	140	163	23	16.4%
Independent Laboratory	42	47	5	11.9%
Dialysis Clinic	94	105	11	11.7%
School-Based Health Services	135	149	14	10.4%
Certified Nurse Practitioner	2,146	2,314	168	7.8%

[20] Analysis is restricted to providers who have a facility or office address located in Kentucky and received a payment from the state Medicaid program for a Medicaid patient.

V. Conclusion

Kentucky's first year of Medicaid expansion has been transformative, resulting in a number of positive outcomes and also a number of challenges for the Commonwealth and its citizens. In 2014, Medicaid expansion reduced the number of uninsured, generated economic value, created financial benefits for Kentucky's hospitals and other health care providers, and began to improve the overall health of Kentuckians.

1. **Kentucky's Medicaid expansion enrollment significantly exceeded estimates for SFY 2014.** The Medicaid expansion enrollment has provided access to affordable health care for hundreds of thousands of Kentuckians, contributing to a 42% or 8.5 percentage point decline in the uninsured rate.

2. **Medicaid expansion is expected to contribute to the Commonwealth's economy and generate a net positive fiscal impact that is $919.1 million higher than had the state decided not to expand Medicaid.** Without Medicaid expansion, the Commonwealth would still face many of the same budgetary challenges that non-expansion states face, including the cost of coverage for prior-eligible Medicaid recipients who signed up as a result of increased health care awareness and outreach brought on by ACA.

3. **Health care providers across the state have seen a net financial gain as a result of care provided to Medicaid recipients.** Providers have received $1.16 billion in payments to cover the cost of care for Medicaid expansion recipients (payments for Medicaid expansion members are 100% federal dollars), and most hospitals are now reporting reductions in uncompensated care charges.

4. **Medicaid expansion has opened up new job opportunities in Kentucky that present the potential for long-term economic gains.** Maintaining economic growth means additional state tax revenues, which are key to addressing the budgetary concerns of paying for Medicaid expansion enrollees, especially once the federal government's share of the Medicaid expansion costs begins to decrease in CY 2017.

5. **Broadening access to health insurance has enabled Kentuckians to take a more active role in managing their health care needs.** Initial experience data indicates that Medicaid expansion enrollees are accessing preventive care. For example, 90,000 Medicaid expansion members had cholesterol screening and 80,000 Medicaid expansion members had preventive dental services. As the experience of other Medicaid expansion states and research has shown, insurance coverage is deeply correlated to improvements in a population's long-term health.

6. **The introduction of many new substance use disorder treatment providers is helping to address this long-standing health care challenge for Kentucky.** Since ACA requires substance use disorder treatment to be covered as an essential health benefit, more than 300 new behavioral health providers have enrolled in Medicaid and at least 13,000 individuals with a substance use disorder diagnosis have received related treatment services.

Maintaining the achievements of the Medicaid expansion implementation will not be without challenges as a new year of Medicaid expansion begins and more individuals enroll. Over time, as more data is available, policymakers and legislators will have additional tools to better assist Kentucky to meet the evolving health care needs of its citizens.

NOTE TO READERS: This report is a point-in-time analysis of Kentucky's Medicaid expansion experience. It relies on data and analysis from a number of sources, including the Centers for Medicare & Medicaid Services, the Kentucky Cabinet for Health and Family Services, Aon Consulting, and the Urban Studies Institute at the University of Louisville to estimate Medicaid expansion's first-year impact and estimate the potential future impact. Enrollment, expenditure, and economic estimates included in this report are estimates based on the information available at the time the analysis was performed. While efforts have been made to generate reasonable estimates founded on appropriate and defensible assumptions, it is important to keep in mind that future-year estimates are inherently subject to many variables. For example, Medicaid enrollment is heavily influenced by economic realities on a state-by-state basis. If the future economic outlook is optimistic and state unemployment is anticipated to be low, then Medicaid enrollment is likely to be lower than anticipated. Alternatively, if the economic outlook is pessimistic, Medicaid enrollment is likely to be higher than anticipated. In order to understand the ongoing impact of Medicaid expansion, it will be important for Kentucky to continue to monitor the assumptions and data in this report and refresh this analysis on a regular basis.

VI. Appendix

Fiscal Impact Tables

- Table 21. 2013 Whitepaper: Net Impact of Medicaid Expansion ($ in millions): This table is included directly from the 2013 Whitepaper.
- Table 22. Updated Analysis: Net Impact of Medicaid Expansion ($ in millions): This table includes updated fiscal impact estimates for Medicaid expansion based on CY 2014 Medicaid expansion experience.
- Table 23. Updated Analysis: Net Impact of ACA without Medicaid Expansion ($ in millions): This table includes updated fiscal impact estimates of not expanding Medicaid based on CY 2014 Medicaid expansion experience.

The fiscal impact tables included in this Appendix and their estimates leverage a methodology similar to that used to develop fiscal impact estimates for the 2013 Whitepaper.

The following line items were provided directly by CHFS based on 2014 claims experience or enacted budget values.

- Community Mental Health Centers
- Local Health Departments
- Department of Corrections
- QCCT Contributions
- Disproportionate Share Hospital
- K-TAP
- Nursing Facility
- Private Insurance for Foster Care Children
- Reductions for BCCTP
- Reductions for Spend-Down Recipients
- KCHIP
- Mental Health DSH Reduction
- ACA-Mandated Benefit Changes
- Administrative Cost Increases

The following line items were provided by the Urban Studies Institute at the University of Louisville, based on estimated Medicaid expansion enrollments provided to their input-output model:

- State Income Taxes
- State Sales Taxes
- Local Occupational & Payroll Taxes

The following enrollment line items were based on the following sources:

- Prior-Eligible (Woodwork) Enrollment:
    - SFY 2014 experienced enrollment: The estimated enrollment of prior-eligibles for 2014 was derived by identifying the difference between average enrollment in 2014 and average enrollment over the period from CY 2012 to CY 2013.
    - SFY 2015 to SFY 2021 estimated enrollment: Applied yearly projections for Medicaid enrollment offered in the CMS 2013 *Actuarial Report on the Financial Outlook of Medicaid* to the SFY 2014 estimate.
    - SFY 2014 to SFY 2021 expenditures: Applied yearly expenditure increase estimates for Medicaid expenditures offered in the CMS 2013 *Actuarial Report on the Financial Outlook of Medicaid* to base rates offered by Kentucky. These rates were then applied to the enrollment estimates.
- Newly Eligible Enrollment:
    - SFY 2014 experienced enrollment: Provided by CHFS.
    - SFY 2015 to SFY 2021 estimated enrollment: Applied yearly projections for Medicaid enrollment offered in the CMS 2013 *Actuarial Report on the Financial Outlook of Medicaid.*
    - SFY 2014 to SFY 2021 expenditures: Applied yearly expenditure increase projections for Medicaid expenditures offered in the CMS 2013 *Actuarial Report on the Financial Outlook of Medicaid* to base rates offered by Kentucky. These rates were then applied to the enrollment estimates.

Enrollment estimates rely on growth projections offered in the CMS 2013 *Actuarial Report on the Financial Outlook of Medicaid*. These growth rates were developed in 2013 prior to experiencing the higher than anticipated take-up rate of Medicaid expansion during the first year. As such, it is likely that these growth rates are generous and thus enrollment and associated expenditures may be less than estimated. Should these enrollment values be less, then tax revenue could also decrease.

Table 21. 2013 White Paper: Net Impact of Medicaid Expansion ($ in millions)

	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21
Federal Funds Replacement								
Community Mental Health Centers	$ 32.0 M	$ 65.3 M	$ 66.6 M	$ 67.9 M	$ 69.3 M	$ 70.7 M	$ 72.1 M	$ 73.5 M
Local Health Departments	$ 12.5 M	$ 25.5 M	$ 26.0 M	$ 26.5 M	$ 27.1 M	$ 27.6 M	$ 28.2 M	$ 28.7 M
General Fund Expenditure Reductions								
Disproportionate Share Hospital	$ 1.9 M	$ 2.3 M	$ 2.3 M	$ 6.9 M	$ 19.2 M	$ 21.5 M	$ 15.4 M	$ 15.4 M
Private Insurance for Foster Care Children	$ .5 M	$ 1.1 M	$ 1.1 M	$ 1.1 M	$ 1.1 M	$ 1.1 M	$ 1.2 M	$ 1.2 M
Spend Down	$ 10.5 M	$ 21.4 M	$ 21.8 M	$ 22.2 M	$ 22.7 M	$ 23.1 M	$ 23.6 M	$ 24.0 M
Inpatient Hospital Care by Department of Corrections	$ 1.4 M	$ 7.0 M	$ 7.2 M	$ 7.5 M	$ 7.7 M	$ 7.9 M	$ 8.2 M	$ 8.4 M
KCHIP	$ -	$ -	$ 22.6 M	$ 47.0 M	$ 48.8 M	$ 50.8 M	$ 26.4 M	$ -
Revenue and Savings Subtotal	**$ 58.8 M**	**$ 122.5 M**	**$ 147.6 M**	**$ 179.1 M**	**$ 195.9 M**	**$ 202.7 M**	**$ 175.0 M**	**$ 151.2 M**
Increased State Taxes								
State Income Taxes	$ 12.1 M	$ 25.1 M	$ 26.5 M	$ 27.0 M	$ 27.3 M	$ 28.3 M	$ 29.4 M	$ 30.0 M
State Sales Taxes	$ 11.9 M	$ 24.6 M	$ 25.9 M	$ 26.5 M	$ 26.8 M	$ 27.7 M	$ 28.8 M	$ 29.4 M
State Tax Subtotal	**$ 24.1 M**	**$ 49.6 M**	**$ 52.4 M**	**$ 53.5 M**	**$ 54.1 M**	**$ 56.0 M**	**$ 58.2 M**	**$ 59.3 M**
Other Taxes								
Local Occupational & Payroll Taxes	$ 4.9 M	$ 10.1 M	$ 10.6 M	$ 10.8 M	$ 11.0 M	$ 11.3 M	$ 11.8 M	$ 12.0 M
Total Revenue Savings & Increases	**$ 87.7 M**	**$ 182.2 M**	**$ 210.6 M**	**$ 243.5 M**	**$ 260.9 M**	**$ 270.0 M**	**$ 245.0 M**	**$ 222.6 M**
Decreased Federal Funds for Continuing Services								
Mental Health DSH Reduction	$ .4 M	$ 1.0 M	$ 1.1 M	$ 2.1 M	$ 6.0 M	$ 9.4 M	$ 8.5 M	$ 7.1 M
Increased General Fund Requirements								
Administrative Cost Increases	$ 6.1 M	$ 10.1 M	$ 11.4 M	$ 11.7 M	$ 11.7 M	$ 11.7 M	$ 11.7 M	$ 11.7 M
Removal of Residency Requirement	$ 2.2 M	$ 4.6 M	$ 4.8 M	$ 5.0 M	$ 5.2 M	$ 5.4 M	$ 5.6 M	$ 5.9 M
Substance Abuse for Current Eligibles	$ 2.8 M	$ 5.7 M	$ 6.0 M	$ 6.2 M	$ 6.4 M	$ 6.7 M	$ 7.0 M	$ 7.2 M
Woodwork Enrollment	$13.5 M	$ 28.5 M	$ 31.2 M	$ 30.6 M	$ 31.9 M	$ 33.1 M	$ 34.5 M	$ 35.8 M
Newly Eligible Enrollment	$ -	$ -	$ -	$ 32.6 M	$ 74.0 M	$ 91.0 M	$ 123.8 M	$ 151.2 M
Total Expenditure Increases and Federal Fund Decreases	**$ 24.9 M**	**$ 49.9 M**	**$ 54.6 M**	**$ 88.3 M**	**$ 135.2 M**	**$ 157.3 M**	**$ 191.1 M**	**$ 218.9 M**
Net Impact	**$ 62.8 M**	**$ 132.3 M**	**$ 156.1 M**	**$ 155.2 M**	**$ 125.7 M**	**$ 112.7 M**	**$ 53.9 M**	**$ 3.7 M**
Cumulative Net Impact	**$ 62.8 M**	**$ 195.1 M**	**$ 351.1 M**	**$ 506.4 M**	**$ 632.1 M**	**$ 744.8 M**	**$ 798.7 M**	**$ 802.4 M**

***Note:** *There are minor differences in totals due to rounding.*

Table 22. Updated Analysis: Net Impact of Medicaid Expansion ($ in millions)

	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21
Federal Funds Replacement								
Department for Behavioral Health, Developmental and Intellectual Disabilities	$ 9.000 M	$ 21.000 M	$ 30.000 M	$ 30.586 M	$ 31.216 M	$ 31.847 M	$ 32.477 M	$ 33.108 M
Department of Public Health	$ 4.000 M	$ 6.000 M	$ 11.700 M	$ 11.925 M	$ 12.195 M	$ 12.420 M	$ 12.690 M	$ 12.915 M
Department of Corrections	$ 5.400 M	$ 11.000 M	$ 11.200 M	$ 11.500 M	$ 11.700 M	$ 11.900 M	$ 12.200 M	$ 12.400 M
General Fund Expenditure Reductions								
QCCT Contributions	$ -	$ 13.788 M	$ 17.788 M	$ 29.788 M	$ 30.306 M	$ 30.824 M	$ 31.601 M	$ 32.119 M
Disproportionate Share Hospital	$ -	$ -	$ -	$ 3.911 M	$ 10.177 M	$ 10.177 M	$ 10.177 M	$ 10.402 M
Reductions for BCCTP	$ .392 M	$ 1.336 M	$ 1.732 M	$ 1.930 M	$ 1.970 M	$ 2.002 M	$ 2.027 M	$ 2.047 M
Reductions for Spend-Down Recipients	$ 2.397 M	$ 13.983 M	$ 37.200 M	$ 37.200 M	$ 37.200 M	$ 37.200 M	$ 37.200 M	$ 37.200 M
K-TAP	$ 1.900 M	$ 9.000 M	$ 9.700 M	$ 9.500 M	$ 9.200 M	$ 9.100 M	$ 8.900 M	$ 8.800 M
Nursing Facility	$ 1.700 M	$ 7.900 M	$ 9.700 M	$ 9.500 M	$ 9.700 M	$ 10.100 M	$ 10.300 M	$ 10.600 M
Private Insurance for Foster Care Children	$ 1.000 M	$ 1.100 M	$ 1.100 M	$ 1.129 M	$ 1.149 M	$ 1.169 M	$ 1.198 M	$ 1.218 M
KCHIP	$ -	$ -	$ 24.600 M	$ 35.000 M	$ 37.400 M	$ 40.000 M	$ 42.900 M	$ 45.800 M
Revenue and Savings Subtotal	**$ 25.789 M**	**$ 85.107 M**	**$ 154.720 M**	**$ 181.969 M**	**$ 192.213 M**	**$ 196.739 M**	**$ 201.670 M**	**$ 206.609 M**
Increased State Taxes								
State Income Taxes	$ 19.300 M	$ 56.317 M	$ 57.220 M	$ 61.905 M	$ 65.353 M	$ 68.378 M	$ 71.360 M	$ 74.442 M
State Sales Taxes	$ 18.130 M	$ 52.903 M	$ 53.751 M	$ 58.152 M	$ 61.391 M	$ 64.232 M	$ 67.034 M	$ 69.929 M
State Tax Subtotal	**$ 37.430 M**	**$ 109.220 M**	**$ 110.971 M**	**$ 120.057 M**	**$ 126.744 M**	**$ 132.610 M**	**$ 138.394 M**	**$ 144.371 M**
Other Taxes								
Local Occupational & Payroll Taxes	$ 6.264 M	$ 18.279 M	$ 18.572 M	$ 20.092 M	$ 21.211 M	$ 22.193 M	$ 23.161 M	$ 24.161 M
Total Revenue Savings & Increases	**$ 69.483 M**	**$ 212.606 M**	**$ 284.263 M**	**$ 322.118 M**	**$ 340.168 M**	**$ 351.542 M**	**$ 363.225 M**	**$ 375.141 M**
Decreased Federal Funds for Continuing Services								
Mental Health DSH Reduction	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Increased General Fund Requirements								
ACA-Mandated Benefit Changes	$ 4.221 M	$ 9.596 M	$ 9.500 M	$ 9.880 M	$ 10.275 M	$ 10.686 M	$ 11.114 M	$ 11.558 M
Newly Eligible Enrollment	$ -	$ -	$ -	$ 74.349 M	$ 173.228 M	$ 215.062 M	$ 294.473 M	$ 362.729 M
Prior-Eligible (Woodwork) Enrollment	$ 15.696 M	$ 41.408 M	$ 43.810 M	$ 34.912 M	$ 37.645 M	$ 40.253 M	$ 42.899 M	$ 45.634 M
Administrative Cost Increases	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Expenditure Increases and Federal Fund Decreases	**$ 19.917 M**	**$ 51.004 M**	**$ 53.310 M**	**$ 119.141 M**	**$ 221.148 M**	**$ 266.001 M**	**$ 348.486 M**	**$ 419.921 M**
Net Impact	**$ 49.566 M**	**$ 161.602 M**	**$ 230.953 M**	**$ 202.977 M**	**$ 119.020 M**	**$ 85.541 M**	**$ 14.739 M**	**$ (44.780) M**
Cumulative Net Impact	**$ 49.566 M**	**$ 211.168 M**	**$ 442.121 M**	**$ 645.098 M**	**$ 764.118 M**	**$ 849.659 M**	**$ 864.398 M**	**$ 819.618 M**

Table 23. Updated Analysis: Net Impact of ACA without Medicaid Expansion ($ in millions)

	SFY 14	SFY 15	SFY 16	SFY 17	SFY 18	SFY 19	SFY 20	SFY 21
Federal Funds Replacement								
Department for Behavioral Health, Developmental and Intellectual Disabilities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Department of Public Health	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Department of Corrections	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
General Fund Expenditure Reductions								
QCCT Contributions	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Disproportionate Share Hospital	$ -	$ -	$ -	$ 3.911 M	$ 10.177 M	$ 10.177 M	$ 10.177 M	$ 10.402 M
Reductions for BCCTP	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Reductions for Spend-Down Recipients	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
K-TAP	$ 1.000 M	$ 1.100 M	$ 1.100 M	$ 1.129 M	$ 1.149 M	$ 1.169 M	$ 1.198 M	$ 1.218 M
Nursing Facility	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Private Insurance for Foster Care Children	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
KCHIP	$ -	$ -	$ 24.600 M	$ 35.000 M	$ 37.400 M	$ 40.000 M	$ 42.900 M	$ 45.800 M
Revenue and Savings Subtotal	**$ 1.000 M**	**$ 1.100 M**	**$ 25.700 M**	**$ 40.040 M**	**$ 48.726 M**	**$ 51.346 M**	**$ 54.275 M**	**$ 57.420 M**
Increased State Taxes								
State Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
State Sales Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
State Tax Subtotal	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Other Taxes								
Local Occupational & Payroll Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Revenue Savings & Increases	**$ 1.000 M**	**$ 1.100 M**	**$ 25.700 M**	**$ 40.040 M**	**$ 48.726 M**	**$ 51.346 M**	**$ 54.275 M**	**$ 57.420 M**
Decreased Federal Funds for Continuing Services								
Mental Health DSH Reduction	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Increased General Fund Requirements								
ACA-Mandated Benefit Changes	$ 4.221 M	$ 9.596 M	$ 9.500 M	$ 9.880 M	$ 10.275 M	$ 10.686 M	$ 11.114 M	$ 11.558 M
Newly Eligible Enrollment	$ 15.696 M	$ 41.408 M	$ 43.810 M	$ 34.912 M	$ 37.645 M	$ 40.253 M	$ 42.899 M	$ 45.634 M
Prior-Eligible (Woodwork) Enrollment	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative Cost Increases	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Expenditure Increases and Federal Fund Decreases	**$ 19.917 M**	**$ 51.004 M**	**$ 53.310 M**	**$ 44.792 M**	**$ 47.920 M**	**$ 50.939 M**	**$ 54.013 M**	**$ 57.192 M**
Net Impact	**$ (18.917) M**	**$ (49.904) M**	**$ (27.610) M**	**$ (4.752) M**	**$ .806 M**	**$ .407 M**	**$ .262 M**	**$ .228 M**
Cumulative Net Impact	**$ (18.917) M**	**$ (68.821) M**	**$ (96.431) M**	**$ (101.183) M**	**$ (100.377) M**	**$ (99.970) M**	**$ (99.708) M**	**$ (99.480) M**

Additional Tables

Table 24. State Medicaid Expansion Program Details

State	Status	Comments
T: Expanding through traditional means W: Expanding through 1115 waiver X: Not expanding at this time C: Considering expanding		
Alabama	X	
Alaska	C	
Arizona	T	
Arkansas	W	• Purchasing QHPs for newly eligibles • Adding cost-sharing component
California	T	
Colorado	T	
Connecticut	T	
Delaware	T	
District of Columbia	T	
Florida	X	
Georgia	X	
Hawaii	T	
Idaho	X	
Illinois	T	
Indiana	W	
Iowa	W	• Purchasing QHPs for beneficiaries 100-138% of the FPL • Enrolling newly eligible individuals below 100% of the FPL into managed care plans in traditional Medicaid
Kansas	X	
Kentucky	T	
Louisiana	X	
Maine	X	
Maryland	T	
Massachusetts	T	
Michigan	W	• Built in cost-sharing requirements for all newly eligible individuals; discounts for healthy behavior
Minnesota	T	
Mississippi	X	
Missouri	C	• Governor has included expansion as part of FY 2016 budget proposal
Montana	C	• Governor has included expansion as part of FY 2016 budget proposal
Nebraska	X	
Nevada	T	
New Hampshire	T	• Began enrolling members Jul. 1, 2014 and coverage Aug. 15, 2014 • Submitted a waiver to continue expansion via premium assistance

State	Status	Comments
New Jersey	T	
New Mexico	T	
New York	T	
North Carolina	X	
North Dakota	T	
Ohio	T	
Oklahoma	X	
Oregon	T	
Pennsylvania	W	• Coverage began January 1, 2015 • Enrolling newly eligible adults up to 138% of the FPL • Built in monthly premium requirements for individuals above 100% of the FPL
Rhode Island	T	
South Carolina	X	
South Dakota	X	
Tennessee	C	• Governor has proposed alternative Medicaid expansion plan
Texas	X	
Utah	C	• Governor has proposed alternative Medicaid expansion plan
Vermont	T	
Virginia	C	• Governor has included expansion as part of FY 2016 budget proposal
Washington	T	
West Virginia	T	
Wisconsin	X	
Wyoming	C	• Department of Health has proposed alternative Medicaid expansion plan

(Kaiser Family Foundation, 2015)

Table 25. First-Year Enrollment vs. Census-Estimated Potential Enrollees in Expansion States (percentage difference)

State	Percent Difference
Arizona	58%
Arkansas	109%
California	76%
Colorado	117%
Connecticut	No Data
Delaware	30%
District of Columbia	122%
Hawaii	24%
Illinois	59%
Iowa	70%
Kentucky	135%
Maryland	154%
Massachusetts	234%
Michigan	50%
Minnesota	130%
Nevada	89%
New Hampshire*	51%
New Jersey	94%
New Mexico	89%
New York	68%
North Dakota	43%
Ohio	71%
Oregon	151%
Pennsylvania*	N/A
Rhode Island	164%
Vermont	596%
Washington	122%
West Virginia	138%

***New Hampshire expanded Medicaid partway through calendar year 2014. Pennsylvania's Medicaid expansion did not begin until January 2015.
Indiana is not included in the data, as it did not announce expansion decision until February 2015.

Table 26. Kentucky FMAP Percentages, FFY 2014-2021

FFY	Kentucky FMAP Percentage
2014	69.83%
2015	69.94%
2016	70.32%
2017	70.32%
2018	70.32%
2019	70.32%
2020	70.32%
2021	70.32%

Table 27. Revenue by Provider Type for Medicaid (Traditional and Expansion), CY 2013-2014

	2013 Medicaid		2014 Medicaid		Difference	
	% of Total Amount Paid	Total Amount Paid	% of Total Amount Paid	Total Amount Paid	% Change	Total Amount Paid
Hospital	32.7%	$1,707,183,000	33.1%	$2,174,983,000	27.4%	$467,799,000
Nursing Facility	16.8%	$878,322,000	14.2%	$930,689,000	6.0%	$52,366,000
Pharmacy	11.1%	$579,431,000	13.9%	$916,618,000	58.2%	$337,187,000
Waiver Services	12.4%	$647,765,000	11.2%	$738,438,000	14.0%	$90,672,000
Primary Care	10.1%	$524,437,000	12.1%	$798,049,000	52.2%	$273,612,000
Other	5.6%	$292,277,000	5.0%	$329,153,000	12.6%	$36,876,000
Behavioral Health Services	5.2%	$273,617,000	5.3%	$348,545,000	27.4%	$74,928,000
ICF/IDD	2.7%	$143,360,000	2.1%	$139,944,000	-2.4%	$ (3,416,000)
Dental Services	2.0%	$103,883,000	1.9%	$123,634,000	19.0%	$19,751,000
Medical Equipment	1.4%	$74,096,000	1.2%	$80,851,000	9.1%	$6,755,000
Total	**100.0%**	**$5,224,371,000**	**100.0%**	**$6,580,904,000**	**26.0%**	**$1,356,530,000**

***Note:** There are minor differences in totals due to rounding.*

Table 28. Payments to Providers for Medicaid Expansion Members – by Member County, CY 2014

County Name	Total Paid	County Name	Total Paid	County Name	Total Paid	County Name	Total Paid
Adair	$5,513,522	Fleming	$5,585,586	Lincoln	$6,648,568	Rowan	$6,241,203
Allen	$5,009,290	Floyd	$14,626,296	Livingston	$2,203,848	Russell	$5,980,695
Anderson	$3,929,550	Franklin	$8,453,245	Logan	$5,500,605	Scott	$9,180,502
Ballard	$1,730,110	Fulton	$1,757,183	Lyon	$1,421,839	Shelby	$6,090,708
Barren	$10,339,244	Gallatin	$2,051,576	McCracken	$13,385,996	Simpson	$3,761,753
Bath	$3,838,483	Garrard	$4,244,508	McCreary	$6,683,138	Spencer	$2,894,634
Bell	$11,871,465	Grant	$5,553,594	McLean	$1,819,116	Taylor	$4,960,604
Boone	$14,209,618	Graves	$9,265,674	Madison	$22,049,155	Todd	$2,403,437
Bourbon	$5,566,195	Grayson	$8,298,061	Magoffin	$5,256,954	Trigg	$2,756,226
Boyd	$15,223,698	Green	$3,222,371	Marion	$5,659,314	Trimble	$2,330,469
Boyle	$7,997,121	Greenup	$10,112,194	Marshall	$5,431,442	Union	$2,684,661
Bracken	$2,703,192	Hancock	$1,556,492	Martin	$4,354,221	Warren	$23,043,668
Breathitt	$7,305,045	Hardin	$21,063,498	Mason	$5,527,792	Washington	$3,470,092
Breckinridge	$5,325,170	Harlan	$15,953,238	Meade	$6,747,732	Wayne	$5,904,276
Bullitt	$15,640,388	Harrison	$4,451,841	Menifee	$1,791,149	Webster	$3,176,841
Butler	$3,407,146	Hart	$5,672,113	Mercer	$4,729,413	Whitley	$13,635,731
Caldwell	$2,458,694	Henderson	$9,351,755	Metcalfe	$3,281,190	Wolfe	$2,992,966
Calloway	$6,857,925	Henry	$4,516,901	Monroe	$3,054,978	Woodford	$4,742,742
Campbell	$15,312,877	Hickman	$1,115,445	Montgomery	$8,760,601	Unknown / Out of State	$1,362,538
Carlisle	$910,356	Hopkins	$9,674,275	Morgan	$4,215,890	TOTAL	$1,073,997,877
Carroll	$3,092,950	Jackson	$5,771,536	Muhlenberg	$7,173,997		
Carter	$9,508,246	Jefferson	$166,749,822	Nelson	$9,992,556		
Casey	$5,193,556	Jessamine	$11,772,229	Nicholas	$3,009,146		
Christian	$11,063,188	Johnson	$9,084,227	Ohio	$6,144,823		
Clark	$10,332,948	Kenton	$31,727,617	Oldham	$4,797,239		
Clay	$9,733,653	Knott	$7,722,168	Owen	$2,525,582		
Clinton	$3,048,603	Knox	$12,537,124	Owsley	$2,532,076		
Crittenden	$2,005,049	Larue	$3,939,940	Pendleton	$2,972,467		
Cumberland	$2,458,506	Laurel	$18,353,556	Perry	$20,653,151		
Daviess	$19,949,291	Lawrence	$6,586,020	Pike	$18,522,517		
Edmonson	$3,229,072	Lee	$3,857,861	Powell	$5,639,455		
Elliott	$2,068,917	Leslie	$6,169,803	Pulaski	$17,580,634		
Estill	$6,079,410	Letcher	$13,382,811	Robertson	$686,145		
Fayette	$57,231,170	Lewis	$4,839,826	Rockcastle	$6,467,368		

Table 29. Payments to Providers for Medicaid Expansion Members – by Provider County, CY 2014

County Name	Total Paid	County Name	Total Paid	County Name	Total Paid	County Name	Total Paid
Adair	$3,342,482	Fleming	$2,196,235	Lincoln	$2,692,278	Rowan	$9,777,277
Allen	$1,528,107	Floyd	$15,521,211	Livingston	$1,199,294	Russell	$3,936,292
Anderson	$963,847	Franklin	$7,789,238	Logan	$2,896,092	Scott	$6,692,858
Ballard	$171,042	Fulton	$1,308,506	Lyon	$273,550	Shelby	$3,326,949
Barren	$11,180,056	Gallatin	$304,976	McCracken	$22,305,316	Simpson	$1,989,304
Bath	$726,386	Garrard	$557,722	McCreary	$2,207,682	Spencer	$503,404
Bell	$8,654,392	Grant	$2,691,576	McLean	$387,163	Taylor	$5,251,374
Boone	$11,196,721	Graves	$6,821,362	Madison	$14,771,705	Todd	$653,756
Bourbon	$4,416,642	Grayson	$5,375,307	Magoffin	$1,701,532	Trigg	$1,223,970
Boyd	$27,385,112	Green	$1,346,459	Marion	$5,358,484	Trimble	$370,423
Boyle	$12,046,725	Greenup	$2,394,944	Marshall	$5,237,069	Union	$1,046,099
Bracken	$225,612	Hancock	$125,926	Martin	$1,361,913	Warren	$33,082,447
Breathitt	$6,775,226	Hardin	$22,418,503	Mason	$6,078,641	Washington	$632,605
Breckinridge	$1,817,703	Harlan	$10,047,631	Meade	$1,496,113	Wayne	$2,599,019
Bullitt	$3,314,172	Harrison	$3,138,643	Menifee	$584,865	Webster	$798,988
Butler	$784,287	Hart	$2,051,484	Mercer	$1,868,673	Whitley	$16,813,965
Caldwell	$1,429,425	Henderson	$7,967,280	Metcalfe	$600,781	Wolfe	$911,311
Calloway	$6,459,261	Henry	$908,049	Monroe	$1,601,308	Woodford	$2,038,800
Campbell	$11,565,189	Hickman	$134,788	Montgomery	$7,170,320	Unknown / Out of State	$85,014,923
Carlisle	$220,132	Hopkins	$11,585,624	Morgan	$1,701,459	TOTAL	$1,073,997,877
Carroll	$2,153,943	Jackson	$2,588,861	Muhlenberg	$3,783,801		
Carter	$2,371,074	Jefferson	$202,333,234	Nelson	$6,026,726		
Casey	$1,916,390	Jessamine	$3,776,891	Nicholas	$356,707		
Christian	$8,767,298	Johnson	$6,042,477	Ohio	$3,146,347		
Clark	$8,348,103	Kenton	$34,722,368	Oldham	$4,803,688		
Clay	$5,408,251	Knott	$1,197,448	Owen	$580,464		
Clinton	$1,608,240	Knox	$5,183,937	Owsley	$827,174		
Crittenden	$998,876	Larue	$818,813	Pendleton	$404,293		
Cumberland	$2,400,846	Laurel	$16,207,593	Perry	$25,586,971		
Daviess	$23,469,109	Lawrence	$4,141,211	Pike	$20,278,033		
Edmonson	$690,916	Lee	$1,093,155	Powell	$1,398,260		
Elliott	$429,929	Leslie	$2,912,835	Pulaski	$19,345,555		
Estill	$2,928,022	Letcher	$9,890,077	Robertson	$2,889		
Fayette	$152,970,817	Lewis	$2,334,240	Rockcastle	$2,706,032		

Figure 25. Health Care Costs Relative to Average Per Capita Statewide Costs by County

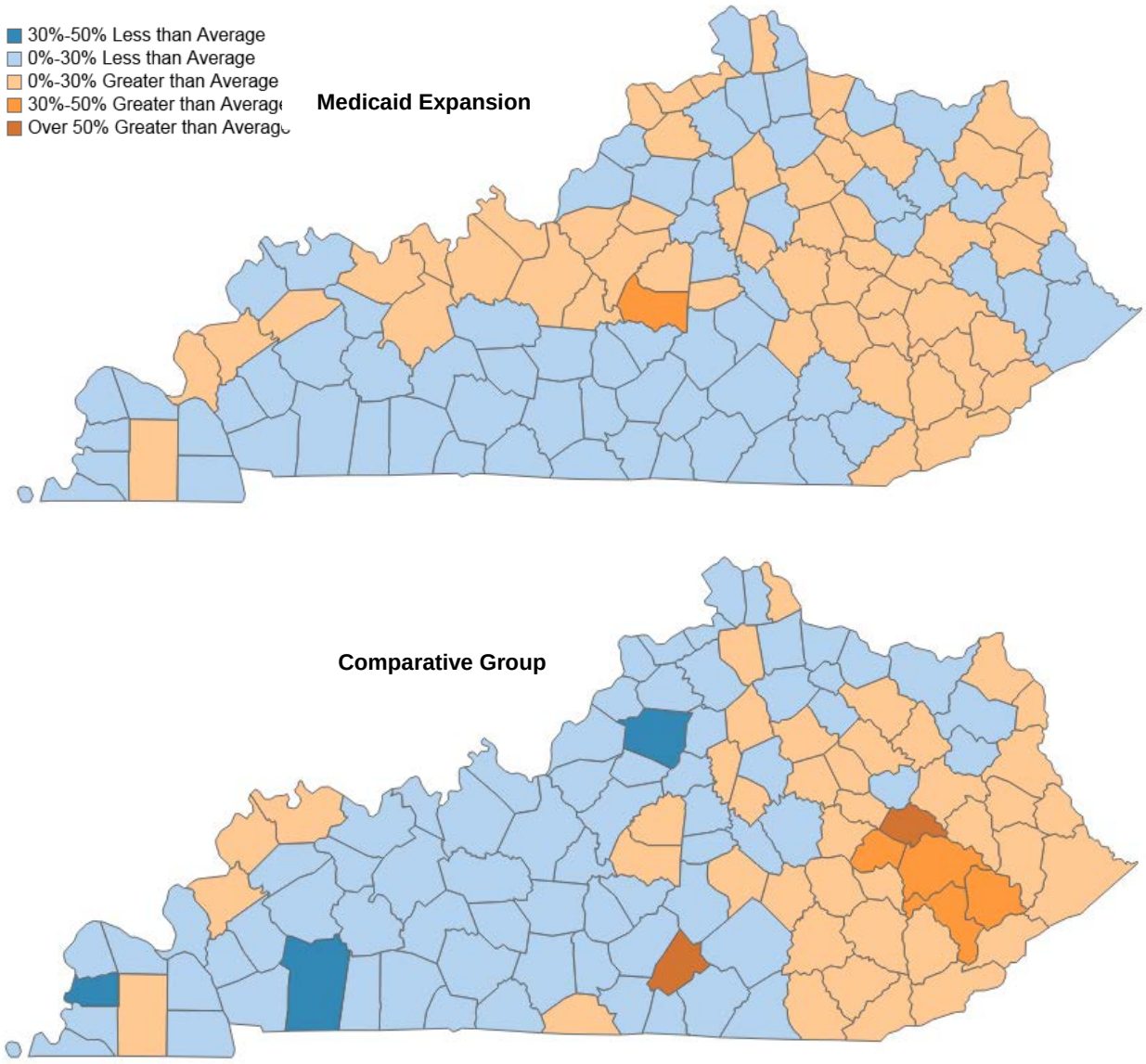


Table 30. Incidence of Chronic Conditions – Age and Gender Breakouts

		Medicaid Expansion Population		Comparative Group	
Chronic Condition	**Age**	**Female**	**Male**	**Female**	**Male**
Hypertension	**56-64**	2.9%	2.1%	0.2%	0.2%
	46-55	3.9%	3.3%	1.3%	0.8%
	36-45	2.4%	2.3%	3.2%	1.4%
	26-35	1.2%	1.3%	2.5%	0.8%
	18-25	0.3%	0.3%	0.5%	0.1%
Hyperlipidemia	**56-64**	2.1%	1.4%	0.1%	0.1%
	46-55	2.6%	2.0%	0.9%	0.6%
	36-45	1.4%	1.2%	1.8%	0.8%
	26-35	0.6%	0.5%	1.2%	0.3%
	18-25	0.2%	0.1%	0.2%	0.0%
Depression	**56-64**	0.9%	0.3%	0.1%	0.0%
	46-55	2.0%	0.9%	0.8%	0.3%
	36-45	1.9%	1.0%	2.8%	0.6%
	26-35	1.9%	1.0%	4.2%	0.5%
	18-25	0.9%	0.4%	1.6%	0.2%
Diabetes	**56-64**	1.2%	0.8%	0.1%	0.1%
	46-55	1.5%	1.2%	0.6%	0.3%
	36-45	0.9%	0.8%	1.2%	0.5%
	26-35	0.5%	0.3%	0.9%	0.2%
	18-25	0.2%	0.1%	0.2%	0.0%
Chronic Obstructive Pulmonary Disease and Bronchiectasis	**56-64**	0.9%	0.6%	0.1%	0.0%
	46-55	1.5%	1.1%	0.5%	0.3%
	36-45	1.0%	0.6%	1.3%	0.4%
	26-35	0.6%	0.4%	1.5%	0.2%
	18-25	0.3%	0.2%	0.5%	0.1%
Asthma	**56-64**	0.3%	0.1%	0.0%	0.0%
	46-55	0.7%	0.3%	0.3%	0.1%
	36-45	0.8%	0.3%	1.1%	0.2%
	26-35	0.8%	0.4%	1.6%	0.2%
	18-25	0.5%	0.3%	0.8%	0.1%

Table 31. 2014 Federal Poverty Level (FPL) Guidelines at 100% and 138% (Medicaid Expansion Eligible)

Household Size	100% FPL	138% FPL (Medicaid Expansion Eligible)
1	$11,670	$16,105
2	$15,730	$21,707
3	$19,790	$27,310
4	$23,850	$32,913
5	$27,910	$38,516
6	$31,970	$44,119
7	$36,030	$49,721
8	$40,090	$55,324

(United States Department of Health & Human Services, n.d.)

Table 32. Preventive Services for Expansion Members

Preventive Service	No. of Members	Total Services Provided	Avg. Services Per Member	Preventive Service	No. of Members	Total Services Provided	Avg. Services Per Member
Non-Annual Physician Office Visit	232,268	1,116,300	4.81	TB Testing	4,455	4,773	1.07
Medication Monitoring	159,886	315,694	1.97	BMI Assessment	4,331	6,592	1.52
LDL-C Screening	89,693	115,922	1.29	Pregnant Women Anemia Screening	2,998	4,506	1.50
Preventive Dental Services	80,136	115,994	1.45	Prostate Cancer Screening	1,802	1,839	1.02
Other Dental Visit	69,085	138,786	2.01	Pregnant Women Rh Incompatibility Screening	1,553	1,845	1.19
Contraceptive Methods and Counseling	55,800	91,490	1.64	Osteoporosis Screening	1,353	1,571	1.16
Hemoglobin A1c Test	45,825	65,893	1.44	Pregnant Women Bacteriuria Screening	1,188	1,462	1.23
Cervical Cancer Screening	33,627	37,961	1.13	Alcohol Misuse Screening and Counseling	498	562	1.13
Annual Wellness or Physical Exam	33,233	34,658	1.04	Pregnant Women Gestational Diabetes Screening	434	501	1.15
Chlamydia Screening in Women	26,689	32,611	1.22	Tobacco Use Counseling and Interventions	428	462	1.08
Breast Cancer Screening	25,584	49,096	1.92	Diabetes Screening	295	302	1.02
Colorectal Cancer Screening	17,186	28,058	1.63	Syphilis Screening	195	210	1.08
HIV Screening	16,128	17,874	1.11	Pregnant Women Hepatitis B Screening	168	171	1.02
Nephropathy Screening	14,443	17,916	1.24	Blood Pressure Monitoring	168	536	3.19
Annual Routine Medical Exam	12,010	12,664	1.05	Cholesterol Abnormalities Screening	166	167	1.01
Annual Influenza Vaccination	10,114	10,269	1.02	Comprehensive HIV/AIDS Care	157	158	1.01
Gonorrhea Screening	10,030	11,255	1.12	Breast Cancer Risk Assessment and Genetic Counseling or Testing	155	157	1.01
HPV Screening	9,775	9,937	1.02	Behavioral or Psychosocial Assessments	44	76	1.73
Well Women Visits	6,647	31,978	4.81	Eye Exam	31	34	1.10
Hepatitis C Virus Infection Screening	6,257	6,469	1.03	Abdominal Aortic Aneurysm Screening	24	24	1.00

Table 33. Uncompensated Care by Hospital, Q1-Q3 Average, CY 2013-2014[21]
(data reported by providers to KHA)

Hospital Name	Q1-Q3 2013 Average	Q1-Q3 2014 Average	Actual Difference	Percent Difference
Baptist Health Corbin	$ 10,870,625	$ 2,505,682	$ (8,364,943)	-77%
Baptist Health La Grange	$ 2,227,830	$ 1,244,234	$ (983,596)	-44%
Baptist Health Lexington	$ 13,990,707	$ 4,662,002	$ (9,328,705)	-67%
Baptist Health Louisville	$ 9,807,493	$ 6,507,965	$ (3,299,528)	-34%
Baptist Health Madisonville	$ 7,139,753	$ 2,623,329	$ (4,516,423)	-63%
Baptist Health Paducah	$ 12,471,248	$ 4,254,874	$ (8,216,374)	-66%
Baptist Health Richmond	$ 2,452,187	$ 1,193,295	$ (1,258,891)	-51%
Bluegrass Community Hospital	$ 602,400	$ 396,621	$ (205,778)	-34%
Bourbon Community Hospital	$ 1,544,553	$ 474,299	$ (1,070,255)	-69%
Breckinridge Memorial Hospital	$ 604,378	$ 304,139	$ (300,239)	-50%
Caldwell Medical Center	$ 504,074	$ 268,556	$ (235,518)	-47%
Carroll County Memorial Hospital	$ 1,135,006	$ 651,188	$ (483,818)	-43%
Casey County Hospital	$ 222,496	$ 104,711	$ (117,785)	-53%
Caverna Memorial Hospital Inc	$ 810,111	$ 530,843	$ (279,268)	-34%
Clark Regional Medical Center	$ 3,226,850	$ 1,338,565	$ (1,888,285)	-59%
Clinton County Hospital	$ 609,080	$ 308,251	$ (300,829)	-49%
Crittenden Health Systems	$ 520,808	$ 215,050	$ (305,759)	-59%
Cumberland County Hospital	$ 490,919	$ 168,153	$ (322,766)	-66%
Ephraim McDowell Fort Logan Hospital	$ 944,878	$ 456,899	$ (487,978)	-52%
Ephraim McDowell Reg Medical Center	$ 6,956,161	$ 2,301,209	$ (4,654,952)	-67%
Flaget Memorial Hospital	$ 3,090,498	$ 1,133,808	$ (1,956,690)	-63%
Fleming County Hospital	$ 897,954	$ 256,774	$ (641,180)	-71%
Frankfort Regional Medical Center	$ 8,627,611	$ 5,212,435	$ (3,415,177)	-40%
Georgetown Community Hospital	$ 4,025,576	$ 2,466,392	$ (1,559,184)	-39%
Hardin Memorial Health	$ 8,333,142	$ 3,294,508	$ (5,038,634)	-60%
Harlan ARH Hospital	$ 4,371,740	$ 1,213,918	$ (3,157,822)	-72%
Harrison Memorial Hospital	$ 1,686,594	$ 647,554	$ (1,039,040)	-62%
Hazard ARH Regional Medical Center	$ 14,417,970	$ 3,828,363	$ (10,589,607)	-73%
Highlands Regional Medical Center	$ 3,167,537	$ 407,873	$ (2,759,664)	-87%
Jackson Purchase Medical Center	$ 3,942,945	$ 1,779,427	$ (2,163,518)	-55%
Jane Todd Crawford Hospital	$ 152,301	$ 67,002	$ (85,300)	-56%
Jennie Stuart Medical Center	$ 3,238,903	$ 736,435	$ (2,502,468)	-77%
Jewish Hospital	$ 14,069,764	$ 6,124,403	$ (7,945,361)	-56%
Jewish Hospital Shelbyville	$ 3,942,775	$ 1,686,195	$ (2,256,580)	-57%
Kentucky River Medical Center	$ 4,398,179	$ 1,142,410	$ (3,255,769)	-74%
Kings Daughters Medical Center	$ 19,187,706	$ 8,132,431	$ (11,055,275)	-58%
Knox County Hospital	$ 309,747	$ 315,090	$ 5,344	2%
Kosair Childrens Hospital	$ 5,591,051	$ 5,706,788	$ 115,737	2%
Lake Cumberland Regional Hospital	$ 15,960,423	$ 2,413,761	$ (13,546,662)	-85%
Livingston Hospital & Healthcare Services	$ 600,065	$ 226,009	$ (374,056)	-62%
Logan Memorial Hospital	$ 1,748,100	$ 299,083	$ (1,449,017)	-83%
Lourdes	$ 8,822,246	$ 3,729,207	$ (5,093,039)	-58%

[21] Includes acute, children's, and critical access hospitals only

Hospital Name	Q1-Q3 2013 Average	Q1-Q3 2014 Average	Actual Difference	Percent Difference
Manchester Memorial Hospital	$ 2,575,234	$ 1,432,154	$ (1,143,080)	-44%
Marcum & Wallace Memorial Hospital	$ 1,473,233	$ 335,650	$ (1,137,582)	-77%
Marshall County Hospital	$ 320,147	$ 192,943	$ (127,205)	-40%
Mary Breckinridge ARH Hospital	$ 1,278,416	$ 294,412	$ (984,004)	-77%
McDowell ARH Hospital	$ 1,017,793	$ 468,597	$ (549,197)	-54%
Meadowview Regional Medical Center	$ 3,405,763	$ 1,443,137	$ (1,962,626)	-58%
Methodist Hospital	$ 4,100,598	$ 223,766	$ (3,876,831)	-95%
Methodist Hospital Union County	$ 844,332	$ 3,410	$ (840,922)	-100%
Middlesboro ARH Hospital	$ 2,377,838	$ 1,183,138	$ (1,194,700)	-50%
Monroe County Medical Center	$ 536,716	$ 198,386	$ (338,330)	-63%
Morgan County ARH Hospital	$ 744,956	$ 282,918	$ (462,038)	-62%
Muhlenberg Community Hospital	$ 2,747,689	$ 2,398,382	$ (349,307)	-13%
Murray-Calloway County Hospital	$ 2,497,695	$ 1,390,372	$ (1,107,323)	-44%
New Horizons Health Systems Inc	$ 148,066	$ 823,140	$ 675,074	456%
Nicholas County Hospital	$ 131,814	$ 14,156	$ (117,658)	-89%
Norton Audubon Hospital	$ 16,998,383	$ 8,955,862	$ (8,042,521)	-47%
Norton Brownsboro Hospital	$ 5,498,292	$ 4,609,033	$ (889,259)	-16%
Norton Hospital	$ 16,327,391	$ 11,496,071	$ (4,831,319)	-30%
Norton Suburban Hospital	$ 9,834,859	$ 7,439,687	$ (2,395,172)	-24%
Ohio County Hospital	$ 914,295	$ 283,473	$ (630,822)	-69%
Our Lady of Bellefonte Hospital	$ 8,218,505	$ 2,816,913	$ (5,401,593)	-66%
Owensboro Health Regional Hospital	$ 17,280,698	$ 7,490,836	$ (9,789,862)	-57%
Parkway Regional Hospital	$ 954,113	$ 543,928	$ (410,185)	-43%
Paul B Hall Regional Medical Center	$ 9,318,092	$ 2,923,432	$ (6,394,661)	-69%
Pikeville Medical Center	$ 19,965,498	$ 7,001,652	$ (12,963,846)	-65%
Pineville Community Hospital	$ 751,020	$ 252,020	$ (498,999)	-66%
Rockcastle Regional Hospital & Respiratory Care Center	$ 944,846	$ 236,269	$ (708,576)	-75%
Russell County Hospital	$ 909,788	$ 253,960	$ (655,828)	-72%
Saint Joseph Berea	$ 1,979,681	$ 748,210	$ (1,231,472)	-62%
Saint Joseph East	$ 6,083,881	$ 3,407,062	$ (2,676,819)	-44%
Saint Joseph Hospital	$ 8,467,982	$ 2,915,844	$ (5,552,138)	-66%
Saint Joseph London	$ 11,352,088	$ 4,026,827	$ (7,325,261)	-65%
Saint Joseph Martin	$ 3,219,487	$ 850,455	$ (2,369,032)	-74%
Saint Joseph Mount Sterling	$ 2,226,984	$ 586,480	$ (1,640,504)	-74%
Shriners Hospital for Children - Lexington	$ 315,070	$ 205,463	$ (109,608)	-35%
Spring View Hospital	$ 2,245,398	$ 888,454	$ (1,356,944)	-60%
St Claire Regional Medical Center	$ 6,413,330	$ 1,874,043	$ (4,539,286)	-71%
St Elizabeth Edgewood	$ 24,255,444	$ 12,226,682	$ (12,028,762)	-50%
St Elizabeth Florence	$ 12,582,851	$ 6,614,044	$ (5,968,807)	-47%
St Elizabeth Fort Thomas	$ 8,683,020	$ 3,609,319	$ (5,073,701)	-58%
St Elizabeth Grant	$ 1,855,760	$ 856,746	$ (999,014)	-54%
St Elizabeth Medical Center North	$ 4,438,745	$ 2,020,837	$ (2,417,907)	-54%
Sts Mary & Elizabeth Hospital	$ 6,939,607	$ 2,243,447	$ (4,696,161)	-68%
T J Samson Community Hospital	$ 4,927,380	$ 2,255,722	$ (2,671,657)	-54%
Taylor Regional Hospital	$ 3,250,769	$ 1,490,968	$ (1,759,801)	-54%
The James B Haggin Memorial Hospital	$ 1,049,833	$ 394,613	$ (655,220)	-62%
The Medical Center at Bowling Green	$ 13,899,975	$ 4,243,406	$ (9,656,569)	-69%
The Medical Center at Franklin	$ 1,698,993	$ 822,292	$ (876,701)	-52%

Hospital Name	Q1-Q3 2013 Average	Q1-Q3 2014 Average	Actual Difference	Percent Difference
The Medical Center at Scottsville	$ 878,543	$ 431,945	$ (446,598)	-51%
Three Rivers Medical Center	$ 3,398,591	$ 1,262,999	$ (2,135,592)	-63%
Trigg County Hospital Inc	$ 458,662	$ 168,375	$ (290,287)	-63%
Tri-Star Greenview Regional Hospital	$ 7,190,314	$ 4,261,134	$ (2,929,180)	-41%
Twin Lakes Regional Medical Center	$ 1,393,291	$ 723,175	$ (670,116)	-48%
UK Chandler Medical Center	$ 51,133,658	$ 14,662,462	$ (36,471,196)	-71%
UK HealthCare Good Samaritan Hospital	$ 15,886,073	$ 5,330,680	$ (10,555,392)	-66%
University of Louisville Hospital	$ 85,059,366	$ 27,335,631	$ (57,723,735)	-68%
Wayne County Hospital Inc	$ 501,279	$ 162,604	$ (338,675)	-68%
Westlake Regional Hospital	$ 944,047	$ 259,477	$ (684,570)	-73%
Whitesburg ARH Hospital	$ 2,795,644	$ 874,203	$ (1,921,441)	-69%
Williamson ARH Hospital	$ 2,541,871	$ 1,201,435	$ (1,340,436)	-53%

Works Cited

American Heart Association. (2011, January 24). *Cost to Treat Heart Disease in United States will Triple by 2030*. Retrieved from AHA Newsroom: http://newsroom.heart.org/news/1241

Baicker, Ph.D., K., Sommers, M.D., B. D., & Epstein, M.D., A. M. (2012, September 13). *Mortality and Access to Care Among Adults after State Medicaid Expansion.* Retrieved from The New England Journal of Medicine: http://www.nejm.org/doi/full/10.1056/NEJMsa1202099#t=article

Baicker, PhD, K. (2013, May 2). *The Oregon Experiment - Effects of Medicaid on Clinical Outcomes.* Retrieved from The New England Journal of Medicine: http://www.nejm.org/doi/full/10.1056/NEJMsa1212321

Brown, D. W., Kowalski, A. E., & Lurie, I. Z. (2015, January). *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?* Retrieved from National Bureau of Economic Research: http://www.nber.org/papers/w20835.pdf

Campaign for Tobacco-Free Kids. (2015, January 8). *The Toll of Tobacco in Kentucky*. Retrieved from http://www.tobaccofreekids.org/facts_issues/toll_us/kentucky

Centers for Disease Control and Prevention. (n.d.). *Overweight and Obesity*. Retrieved from http://www.cdc.gov/obesity/data/adult.html

Centers for Disease Control and Prevention. (n.d.). *Smoking & Tobacco use Fast Facts*. Retrieved from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/

Centers for Medicare & Medicaid Services. (2014, November). *Medicaid and CHIP: August and September 2014 Monthly Enrollment Updated November 2014.* Retrieved from http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/updated-september-2014-enrollment-data.pdf

DeLeire, T., Joynt, K., & McDonald, R. (2014). *Impact of Insurance Expansion on Hospital Uncompensated Care Costs in 2014.* United States Department of Health & Human Services.

Haile, B., & Brandes, G. (2014, January). *State Medicaid Choices and the Hidden.* Retrieved from Jackson Hewitt Tax Service: http://www.jacksonhewitt.com/uploadedfiles/jacksonhewitt2014com/content/resource_center/healthcare_and_taxes/resources/medicaidchoices_taxsurprises.pdf

Harvard School of Public Health. (2012, Fall). *Public Health and the U.S. Economy*. Retrieved from http://www.hsph.harvard.edu/news/magazine/public-health-economy-election/

House Bill 235 (2014 General Assembly, Commonwealth of Kentucky).

Kaiser Family Foundation. (2015, January 27). *Status of State Action on the Medicaid Expansion Decision*. Retrieved from State Health Facts: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

Kentucky Cabinet for Health and Family Services. (2013). *Analysis of the Affordable Care Act (ACA) Medicaid Expansion in Kentucky.*

Kentucky Cancer Consortium. (July 2013). *Resource Plan.*

Kentucky Health Benefit Exchange. (n.d.).

Kentucky League of Cities. (n.d.). *Drug Abuse*. Retrieved from: http://www.klc.org/info/detail/77/Drug_Abuse

National Federation of Independent Business (NFIB) v. Sebelius, Docket No. 11-393 (Supreme Court of the United Std June 28, 2012).

Obestity Fact Sheet. (n.d.). Retrieved from Partnership for a Fit Kentucky: http://fitky.wordpress.cdpehs.com/wp-content/uploads/sites/2/2014/09/Obesity-Fact-Sheet-updated.pdf

Office of Governor of Kentucky Steve Beshear. (2014). *kyhealthnow 2019 goals*. Retrieved from kyhealthnow: http://governor.ky.gov/healthierky/kyhealthnow/pages/default.aspx

Office of the Actuary, Centers for Medicare & Medicaid Services, United States Department of Health & Humans Services. (2013). *2013 Actuarial Report on the Financial Outlook for Medicaid.*

Protecting Access to Medicare Act of 2014, Public Law (P.L.) 113-93.

Schwartz, A. L., & Sommers, B. D. (2014, January). Moving For Medicaid? Recent Eligibility Expansions Did Not Induce Migration From Other States. *Health Affairs*, pp. 88-94.

Sommers, M.D., B. D., Long, PhD, S. K., & Baicker, PhD, K. (2014, May 6). *Changes in Mortality after Massachusetts Health Care Reform: A Quasi-experimental Study.* Retrieved from Annals of Internal Medicine: http://annals.org/article.aspx?articleid=1867050

The State of Obesity. (n.d.). *Fast Facts: Economic Costs of Obesity*. Retrieved from: http://stateofobesity.org/facts-economic-costs-of-obesity/

Trust for America's Health. (2012, September). *Adult Obesity Rate in Kentucky Could Reach 60.1 Percent by 2030, According to New Study.* Retrieved from F as in Fat: How Obesity Threatens America's Future 2012: http://healthyamericans.org/reports/obesity2012/?stateid=KY

United States Census Bureau. (2012). Small Area Health Insurance Estimates.

United States Census Bureau. (2014, April 15). *Statement by Census Bureau Director John H. Thompson on Improved Health Insurance Questions in the Current Population Survey*. Retrieved from: http://www.census.gov/newsroom/releases/archives/directors_corner/cb14-67.html

United States Department of Health & Human Services. (n.d.). *Federal Poverty Level (FPL)*. Retrieved from HealthCare.gov: https://www.healthcare.gov/glossary/federal-poverty-level-FPL/

United States Department of Labor: Bureau of Labor Statistics. (2015, January 14). Databases, Tables & Calculators by Subject.

Witters, D. (2014, August 5). *Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate*. Retrieved from Gallup: http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx

Wright, S. (n.d.). *The Impact of Health Insurance Reform in Massachusetts.* Retrieved from The National Bureau of Economic Research: http://www.nber.org/digest/nov10/w16012.html